

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Dr. B. Butler for certificate
 100 - Cleared With
 MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH													
00852 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2840 Norwood Road</u>						00854 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md. 15-1</u> d. STREET ADDRESS <u>2840 Norwood Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Marjorie Addison</u> First Middle Last 4. DATE OF DEATH <u>Jan 31 1966</u> Month Day Year													
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3 June 1921</u> 9. AGE (in years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Norbeck Md</u>		12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <u>Charles Ellison</u>						14. MOTHER'S MAIDEN NAME/ <u>Jeney</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO.		17. INFORMANT <u>Joseph Addison</u> Address <u>2840 Norbeck Rd</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial degeneration</u> 4222 OUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO (b) (c)												INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>31 Jan 1966</u> to <u>31 Jan 1966</u> , that (I) (we) last saw the deceased alive on <u>31 Jan 1966</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>D. A. Butler</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <u>D. A. Butler</u>						22d. ADDRESS <u>2710 Norbeck Rd Silver Spring, Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/3/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial</u>				23d. LOCATION (City, town or county) (State) <u>Sandy Spring, Md.</u>					
24. FUNERAL DIRECTOR <u>Robert L. Snoderen</u> ADDRESS <u>Rockville, Md.</u>						25a. REC'D BY REGISTRAR <u>FEB 7 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

00853

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>42-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON, D.C.</u>			
c. LENGTH OF STAY in 1b <u>2yrs. 5 mon.</u>				d. STREET ADDRESS <u>173 ADAMS ST., N.W.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wheaton Nursing Home 11901 Georgia Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Louis A. Alexander</u>				4. DATE OF DEATH <u>1 3 19 66</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 1, 1870</u>	
9. AGE (In years last birthday) <u>95</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u>			
10b. KIND OF BUSINESS OR INDUSTRY <u> </u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Timothy Alexander</u>				14. MOTHER'S MAIDEN NAME <u>Mary Susan Jackson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNKNOWN</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>ELLA M. G. PINKNEY</u>				Address <u>SEE # 2 D</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Infarction</u> 4330 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Complete Heart Block (Past 6 yrs)</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, lecture, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 12, 1963</u> to <u>Jan 3, 1966</u> , that (I) (we) last saw the deceased alive on <u>Jan 3, 1966</u> , and that death occurred at <u>3:20 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Genellohen M.D.</u>				22b. DATE SIGNED <u>Jan 3, 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>GEORGE H. COHEN, M.D.</u>				22d. ADDRESS <u>1106 SPRING ST. SILVER SPRING, M.D.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/8/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HARMONY MEM. PARK</u>		23d. LOCATION (City, town or county) (State) <u>HIGHLAND PARK, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Cobert 29110 June 1820-92 D.C.</u>				25a. REC'D BY REGISTRAR <u>JAN 7 1966</u>			
				25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

00823

WASHINGTON, D.C.

TO: HON. J. EDGAR HOOVER

X

VIRGINIA

WILLIAM G. FINNEY, JR.

HIGHLAND PARK, VIRGINIA

HARMONY MEN. PARK

COPIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00854

CERTIFICATE OF DEATH

00836

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUBURBAN				d. STREET ADDRESS 5533 CHARLES ST.			
3. NAME OF DECEASED (Type or print) PERCY F. ALLEN				4. DATE OF DEATH Month JAN. Day 1 Year 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/11/79		9. AGE (In years lost birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (County & State, or foreign country) Maryland (Wicomico)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM F. ALLEN				14. MOTHER'S MAIDEN NAME NORA DISHARON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-46-2253		17. INFORMANT SON (HENRY E. ALLEN) Address Bethesda, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Substernal Obstruction with DUE TO Generalized abdominal + Liver (b) Carcinoma - Primary from Rectum DUE TO Termined (c) 154X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 2-3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Inanition and Sepsis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-29-1965 , to 1-1-1966 that (I) (we) lost the deceased alive on 12-31-1965 , and that death occurred at 79 M, from causes and on the date stated above.							
22a. SIGNATURE Arch L. Riddick MD				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-1-66	
22c. PHYSICIAN'S NAME (Type) ARCH L. RIDDICK				22d. ADDRESS 1835 I ST., NW, WASH., D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF I-4-66		23c. NAME OF CEMETERY OR CREMATORY ALLEN CEMETERY		23d. LOCATION (City or Town) (County) (State) SALISBURY MARYLAND	
24. FUNERAL DIRECTOR JOSEPH GAWLER'S SONS WASHINGTON, D.C.				25a. REC'D BY REGISTRAR JAN 7 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

00888

OFFICE OF PLAIN

00888

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00855 CERTIFICATE OF DEATH 00837

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>1 Mo</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>2101 Fairland Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Arcilesi</u> Last <u>Arcilesi</u>		4. DATE OF DEATH Month <u>1</u> Day <u>14</u> Year <u>1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-19-90</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAILOR</u>		9b. AGE (In years last birthday) <u>75</u> yrs.	
10a. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u>	
13. FATHER'S NAME <u>CARMELLO ARCILESI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>?</u>		14. MOTHER'S MAIDEN NAME <u>MARIE</u>	
16. SOCIAL SECURITY NO. <u>216-03-0684</u>		17. INFORMANT <u>Hospital Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>① Myocardial Infarction</u> <u>4201</u> DUE TO (b) <u>② Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>③ Congestive Heart Failure</u> <u>④ Cerebral Vascular Accident</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>① Atelectasis</u> <u>② Urinary Tract Infection</u> <u>③ Arteriosclerosis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-1-1965</u> to <u>1-14-1966</u> , that (II) (we) last saw the deceased alive on <u>1-14-1966</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Alan R. Gair</u>		22b. DATE SIGNED <u>1-14-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALAN R. GAIR M.D.</u>		22d. ADDRESS <u>7777 Maple Ave, Takoma Park, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Jan. 17 1966</u>		23b. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER</u>	
23c. LOCATION (City, town or county) <u>4430 BELAIR RD</u>		23d. (State) <u>MD</u>	
24. FUNERAL DIRECTOR <u>Frank Della hove</u>		25a. REC'D BY REGISTRAR <u>322 S. HIGH ST</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JAN 17 1966</u>	

00822

00822

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "A", "R", "C", "A", "T", "I", "O", "N", "S" are visible.]

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VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00856					00838						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)						
a. COUNTY Montgomery County					a. STATE Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton, Maryland					b. COUNTY Montgomery						
c. LENGTH OF STAY IN 1b 2 months					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md.						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home					d. STREET ADDRESS 10000 Sutherland Rd.						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First Reid		Middle R. N.		Last Ashworth		4. DATE OF DEATH Month 1 Day 31 Year 19 66		
5. SEX M		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-10-1877		9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months 9 Days 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Director of food service in health dept.		10b. KIND OF BUSINESS OR INDUSTRY D.C. Health Dept.		11. BIRTHPLACE (County & State, or foreign country) Providence, R.I.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 578-42-7066A			17. INFORMANT Richard R. Comer					
						Address 10000 Sutherland Road Silver Spring, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X cerebral vascular accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) long standing coronary artery disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 years										INTERVAL BETWEEN ONSET AND DEATH 6 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 11-28 , 19 65 , to 1-31 , 19 66 , that (I) (we) last saw the deceased alive on 1-27 , 19 66 , and that death occurred at 8:45 A.M., from the causes and on the date stated above.											
22a. SIGNATURE Dr. John Rogers										22b. DATE SIGNED 1-31-66	
22c. PHYSICIAN'S NAME (Type) Dr. John Rogers					22d. ADDRESS 1919 Seminary Rd., Silver Spring, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 2-2-66		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery			23d. LOCATION (City, town or county) (State) Washington, D.C.			
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.					ADDRESS 8434 Georgia Avenue Silver Spring, Md.			25a. REC'D BY REGISTRAR FEB 4 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

X6806

23902

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00857

00839

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL		d. STREET ADDRESS BOX 26, RFD 2	
3. NAME OF DECEASED (Type or print) Lawrence First Brent Middle BAILEY Last		4. DATE OF DEATH Month JANUARY Day 21 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/10/1882
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. Spanish-American	
17. INFORMANT Hospital Records		Address Olney, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis infection 0969 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senile DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days 6-8 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan-21-1966 , to Jan-21-1966 , that (I) (we) last saw the deceased alive on Jan-21-1966 , and that death occurred at PM M, from the causes and on the date stated above.			
22a. SIGNATURE William C. Miller		22b. DATE SIGNED Jan-21-1966	
22c. PHYSICIAN'S NAME (Type) WILLIAM C. MILLER		22d. ADDRESS Gaithersburg - Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-24-66	
23c. NAME OF CEMETERY OR CREMATORY Goshen		23d. LOCATION (City, town or county) (State) Goshen, Mont. Md.	
24. FUNERAL DIRECTOR Francis H. Barber		25a. REC'D BY REGISTRAR LAYTONSVILLE, Md.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JAN 25 1966	

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UNITED STATES DEPARTMENT OF JUSTICE

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UNITED STATES DEPARTMENT OF JUSTICE

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Yes

Spencer - New York

Harold J. Spencer

Orney, Md.

James H. Miller
Attorney

4 copies
6-8-53

Jan-21-54

Jan-21-54

William C. Miller
Attorney

Jan-21-54

Goshen, Mont. Md.

Goshen

1-24-56

Burial

Laytonville, Md.

Francis. Barber

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleaned by Dr. Leap/EC

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00859					00840						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY		Montgomery			a. STATE		Maryland				
		MARYLAND			b. COUNTY		Montgomery				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Silver Spring			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Silver Spring 15-1				
c. LENGTH OF STAY IN 1b		DOA			d. STREET ADDRESS		10011 Markham St.				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					e. IS RESIDENCE ON A FARM?						
Holy Cross Hospital					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH		
Vasilios			George		Banos		January		20 19 66		
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.				
Male	White	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	12/6/90	75 yrs.	Months	Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Restauranteur		Restaurant		Messinia, Greece		USA					
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
George Banos				UNKNOWN							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>		W.W. I		UNKNOWN		Pete Demestihias		Same address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a)										443 X	
DUE TO										Acute cordic arrhythmia	
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.										15 yrs	
DUE TO (b)										Accelerated Hypertension	
DUE TO (c)										Carcinoma of Right Atrial Pelvis	
DUE TO (c)										Chronic pyelonephritis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED?	
										YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m.		19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from 19 63, to 1-20, 19 66, that (I) (we) last saw the deceased alive on 12-28 19 65, and that death occurred at 6 45 AM, from the causes and on the date stated above.											
22a. SIGNATURE										22b. DATE SIGNED	
Bernard H. Ostrow											
22c. PHYSICIAN'S NAME (Type)										22d. ADDRESS	
BERNARD H. OSTROW										8107 EASTERN AVE. S.S. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State)			
Burial		1-24-66		Glenwood Cemetery		Washington, D.C.					
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Funeral Home 7400 St. Louis Ave.				JAN 26 1966				John J. Judge			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Items 18&21 Film G375-144/66 TR										
MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
00858 00841										
1. PLACE OF DEATH a. COUNTY Mont gomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 15-1					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS HOSPITAL					d. STREET ADDRESS 12107 Selfridge Road					
3. NAME OF DECEASED (Type or print) WILLIAM CLARENCE BARKER					4. DATE OF DEATH Month Jan. Day 14 Year 19 66					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 7, 1921		9. AGE (In years last birthday) 44 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Barber Shop		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13. FATHER'S NAME William Gilmer Barker					14. MOTHER'S MAIDEN NAME Zella Davis					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II					16. SOCIAL SECURITY NO.		17. INFORMANT Wife Address Carrie L. Barker Same as Item 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive, intracerebral hemorrhage; Hypertensive 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) cardiovascular disease. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH										
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)										
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE Belden R. Reap M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 11502 Grandview Av Address (Street, City, town, or county) Wheaton, Md. Jan. 14, 1966 22. DATE SIGNED										
EXAMINER'S NAME (Type) BELDEN R. REAP										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF January 17, 66 23c. NAME OF CEMETERY OR CREMATORY Buffalo Presbyterian Cem 23d. LOCATION (City, town or county) (State) Sanford North Carolina										
24. FUNERAL DIRECTOR Robert A. Pumphrey Bethesda, Maryland 25a. REC'D BY REGISTRAR Jan 19 1966 25b. REGISTRAR'S SIGNATURE Charles Judge										

Robert A. Humphrey, Bethesda, Maryland

RECEIVED 2.28.50

Jan. 14, 1950

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>26 Froude Circle</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>26 Froude Circle</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>William</u> Last <u>Barrett</u>			4. DATE OF DEATH Month <u>January</u> Day <u>3</u> Year <u>1966</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 26, 1889</u>		9. AGE (In years last birthday) <u>76</u> yrs. IF UNDER 1 YEAR: Months <u>7</u> Days <u>7</u> Hours <u>7</u> Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brick Mason</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>			12. CITIZEN OF WHAT COUNTRY? <u>US.</u>	
13. FATHER'S NAME <u>Luther Morris Barrett</u>					14. MOTHER'S MAIDEN NAME <u>Alice</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <u>577 09 1481</u>		17. INFORMANT Address <u>Ella Louise Barrett (same as #1.)</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Visceral Failure</u> 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Sensitivity</u>								INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Deabetes Mellitus</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>January 5, 1966</u> to <u>Jan 3, 1966</u> , that (I) (we) last saw the deceased alive on <u>Jan 3, 1966</u> , and that death occurred at <u>3:00 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Francis T. Sharpe</u>					22b. DATE SIGNED <u>1-3-66</u>		22c. PHYSICIAN'S NAME (Type) <u>Francis T. Sharpe M.D.</u>		
22d. ADDRESS <u>4105 Wisconsin Ave Wash D.C.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 6, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rosedale Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Martinsburg, West Va.</u>		
24. FUNERAL DIRECTOR <u>H. Don. DeVol</u>				ADDRESS <u>2224 Wis. Ave. Wash. D.C.</u>		25a. REC'D BY REGISTRAR <u>10 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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CERTIFICATE OF DEATH

STATE OF NEW YORK

1. Name of deceased: [illegible]
2. Date of death: [illegible]
3. Place of death: [illegible]
4. Cause of death: [illegible]
5. Age at death: [illegible]
6. Sex: [illegible]
7. Race: [illegible]
8. Marital status: [illegible]
9. Occupation: [illegible]
10. Education: [illegible]
11. Date of birth: [illegible]
12. Place of birth: [illegible]
13. Name of informant: [illegible]
14. Signature of informant: [illegible]
15. Date of certificate: [illegible]
16. Name of registrar: [illegible]
17. Signature of registrar: [illegible]
18. Date of registration: [illegible]
19. Name of physician: [illegible]
20. Signature of physician: [illegible]
21. Date of medical certificate: [illegible]
22. Name of medical examiner: [illegible]
23. Signature of medical examiner: [illegible]
24. Date of medical examination: [illegible]
25. Name of coroner: [illegible]
26. Signature of coroner: [illegible]
27. Date of coroner's certificate: [illegible]
28. Name of funeral home: [illegible]
29. Signature of funeral home: [illegible]
30. Date of funeral: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00843

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg d. STREET ADDRESS Route #1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle G. Last Barrington		4. DATE OF DEATH January 31, 1966	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 15, 1909
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months 56 Days 15	11. IF UNDER 24 HRS. Hours 15 Min. 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dennis Barrington		14. MOTHER'S MAIDEN NAME Hattie Gibson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Lucille Barrington (wife)		Address Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 4201 DUE TO H.C.U.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial Asthma INTERVAL BETWEEN ONSET AND DEATH Minutes Years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 1965 to 1-31, 1966 , that (I) (we) last saw the deceased alive on 1-4, 1966 , and that death occurred at 12:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Jack Shumacher		22b. DATE SIGNED 2-1-66	
22c. PHYSICIAN'S NAME (Type) Jack Shumacher		22d. ADDRESS 105 Russell Ave. Gaithersburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/5/66	
23c. NAME OF CEMETERY OR CREMATORY Ash Memorial Cem.		23d. LOCATION (City, town or county) (State) Sandy Spring, Md.	
24. FUNERAL DIRECTOR Robert L. Snowden		25a. REC'D BY REGISTRAR FEB 7 1966	
ADDRESS Rockville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
00862						00844						
1. PLACE OF DEATH a. COUNTY						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE						
MONTGOMERY MARYLAND						MARYLAND MONTGOMERY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				15-1		
SILVER SPRING						SILVER SPRING						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
HOLY CROSS HOSPITAL OF SILVER SPRING						11501 ELWIN ST						
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH		Month		Day Year		
VIRGINIA BARRY			B		BARRY		JAN		5		1966	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days Hours Min.		
F		W				8/18/01		64 yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?			
Housewife						Penna.			U.S.A.			
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME						
Earl Babcock						Regena Hartmann						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT			Address			
						Regena R. Davis			3314 Silverside Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CERE BRO VASCULAR ACCIDENT 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSION DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE												
INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 5 YRS												
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>												
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from _____, 1963, to 1/5, 1966, that (I) (we) last saw the deceased alive on 1/5 1966, and that death occurred at 2:40 PM, from the causes and on the date stated above. 22a. SIGNATURE 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS												
HENRY W. STOUT M.D. 10011 GEORGIA AVE SILVER SPRING MD												
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)				
Burial			1/8/66		Grace P. E. Cemetery			Talleyville, Delaware				
24. FUNERAL DIRECTOR McCreary F. H., Wilcox, Dela.						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		DATE 1/6/66		
JAN 10 1966												

2800

2000

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR-STATE
HEALTH DEPT.

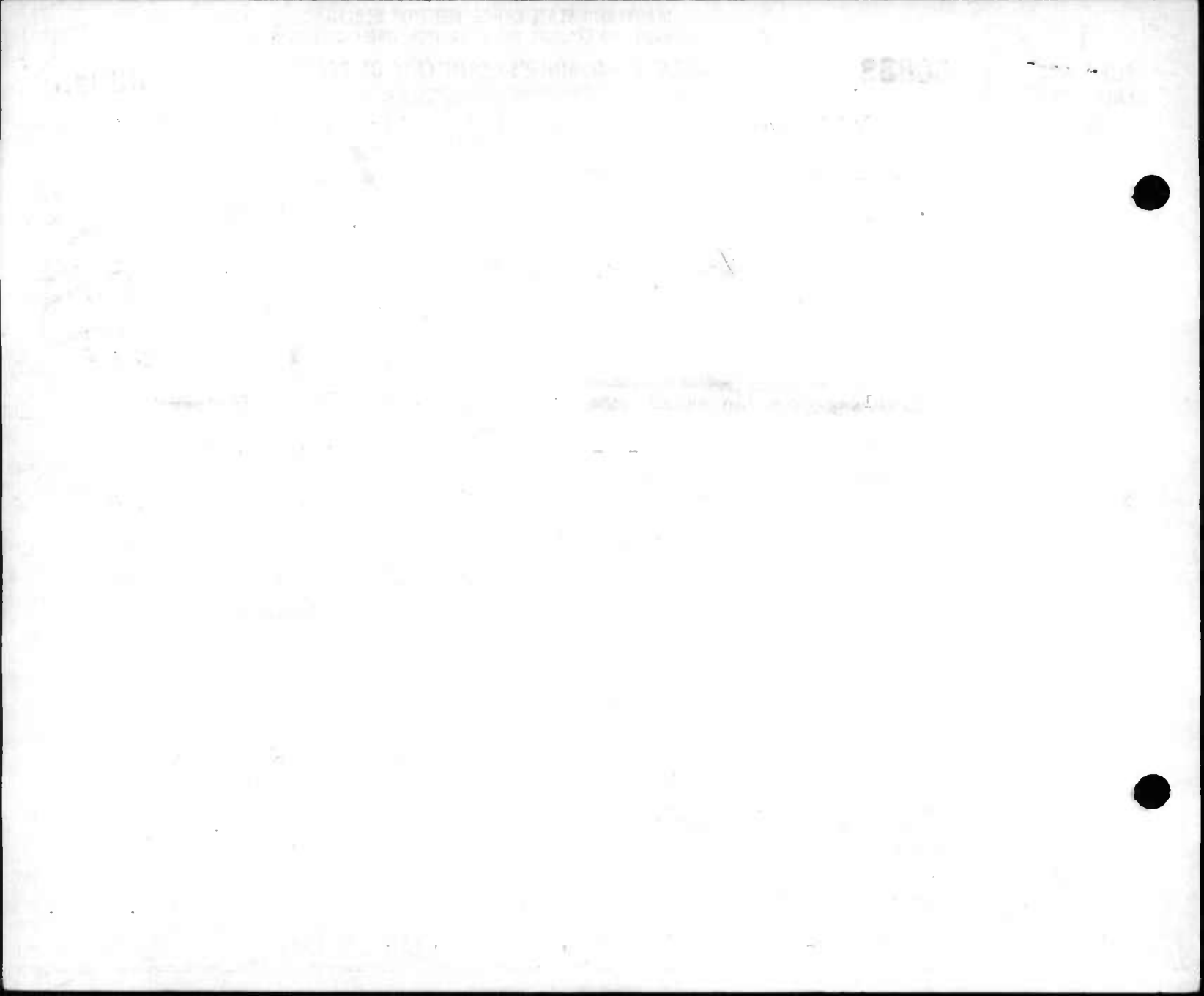
00863

00845

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seneca</u>				c. LENGTH OF STAY IN 1b <u>241?</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Berryville Rd.</u>				d. STREET ADDRESS <u>Berryville Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Lucille</u> Middle <u>Francis</u> Last <u>Barton</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>22</u> Year <u>1966</u>			
5. SEX <u>Fe.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-13-1929</u>	
9. AGE (In years last birthday) <u>36</u> Yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter Franklin Baker</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Dare Halterman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-24-3558</u>		17. INFORMANT <u>Joseph E. Barton Husband</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Pulmonary Emboli</u> DUE TO (b) <u>Veinous Stasis in Legs</u> DUE TO (c) <u>Massive Obesity - wt. 400 lbs.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Weeks</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John S. Ball</u> M.D.				22. DATE SIGNED <u>1/23/66</u>			
EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/27/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville Montg. Md.</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler-1331 Rockville Pike, Rockville</u>				25a. REC'D BY REGISTRAR <u>JAN 26 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00864

CERTIFICATE OF DEATH

00846

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN b. 2hrs. 45 mins. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Mont. Co. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 512- W. Montgomery Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Augustus First A. Middle Bell Last Bell		4. DATE OF DEATH Jan. 2 1966 Month Jan. Day 2 Year 1966	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/19/1899 9. AGE (In years last birthday) 66yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Bureau of Engraving	
11. BIRTHPLACE (County & State, or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Bell		14. MOTHER'S MAIDEN NAME -----	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Helen Bell/wife/ same as above.		Address -----	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4201 DUE TO (b) Coronary occlusion (arteriosclerosis) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. ----- (c) -----			INTERVAL BETWEEN ONSET AND DEATH 8 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/8 , 19 65 , to Jan 2 , 19 66 , that (I) (we) lost saw the deceased alive on Jan 2 19 66 , and that death occurred at ----- M, from causes and on the date stated above.			
22a. SIGNATURE G. Bowditch Hunter Jr.		22b. OATE SIGNED 1-3-66	
22c. PHYSICIAN'S NAME (Type) G. Bowditch Hunter, Jr., M.D.		22d. ADDRESS D. Rockville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/6/66	23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial	23d. LOCATION (City or Town) (County) (State) Suitland, Md.
24. FUNERAL DIRECTOR George R. Snowden		25a. REC'D BY REGISTRAR JAN 6 1966	
ADDRESS Rockville		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00884

CRIMINAL RECORDS

00884

RECORDS SECTION
JAN 19 1964
FBI - NEW YORK

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

00865

00847

1. PLACE OF DEATH a. COUNTY Montgomery Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring,		c. LENGTH OF STAY IN 1b 1 1/2 hr.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hosp. of Sil. Spring		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ann Middle NMN Lost Bennett		4. DATE OF DEATH Month Jan Day 28 Year 19 66	
5. SEX female	6. COLOR OR RACE cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 6, 1918
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inventory Clerk		10b. KIND OF BUSINESS OR INDUSTRY Retail Merchandise	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Petrauskas		14. MOTHER'S MAIDEN NAME Anna Blazauskas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO. 262-44-3545	
17. INFORMANT Newton Bennett-husband		Address Add. same as deceased	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5810 Acute myocardial failure accompanied by DUE TO (b) Electrolyte imbalance and hepatic cirrhosis. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) BELOEN R. REAP, M.D.		22. DATE SIGNED JAN. 28, 1966	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 2-1-66	
23c. NAME OF CEMETERY OR CREMATORY Grove Park Crematory		23d. LOCATION (City or Town) (County) (State) Miami, Florida	
24. FUNERAL DIRECTOR Warner E. Humphrey, Inc.		25a. REC'D BY REGISTRAR FEB 3 1966	
ADDRESS 8434 Georgia Avenue Silver Spring, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

03830

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00866

00848

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN b <u>20 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont. Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> <u>15-1</u> d. STREET ADDRESS <u>731- Monroe Street</u>					
3. NAME OF DECEASED (Type or print) First <u>Caryl</u> Middle <u>J.</u> Last <u>Bielaski</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>28</u> Year <u>1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/24/13</u>		9. AGE (In years last birthday) <u>52</u> yrs. IF UNDER 1 YEAR: Months <u>9</u> Days <u>14</u> IF UNDER 24 HRS.: Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (County & State, or foreign country) <u>Edgar - Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Carl G. Whitstuck</u>				14. MOTHER'S MAIDEN NAME <u>Bessie E. Leach</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>230-16-6764</u>		17. INFORMANT Address <u>Thelma (Frank) Same as above</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>2021 Pulmonary Edema and Congestion</u> DUE TO <u>and Pleural effusion (1500 cc Each side)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Reticuloendotheliosis, systemic, Malignant</u> DUE TO (c) <u></u>								INTERVAL BETWEEN ONSET AND DEATH <u>5-6 days</u> <u>2-3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Nov.</u> , 19 <u>62</u> , to <u>Jan. 28</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Jan. 28</u> , 19 <u>66</u> , and that death occurred at <u>11:12</u> M, from causes on and on the date stated above.									
22a. SIGNATURE <u>A. Bowditch Hunter, Jr.</u>				22b. DATE SIGNED <u>Jan. 27, 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>G. BOWDITCH HUNTER, JR.</u>		22d. ADDRESS <u>50 W. Edmonston Dr., Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-1-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington Virginia</u>			
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 4 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

24200

STATE OF TEXAS

38330

[Faint, mostly illegible text and markings covering the majority of the page, possibly representing a document or ledger.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00867					00849				
Item #8 Film #5372 1/13/66									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u> c. LENGTH OF STAY IN b <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital of Silver Springs</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u> d. STREET ADDRESS <u>2009 Luzerne</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>HARRY J Biondi, Jr.</u>					4. DATE OF DEATH Month <u>January</u> Day <u>5</u> Year <u>1966</u>				
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11 JAN, 1887</u>		9. AGE (In years last birthday) <u>78</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Draftsman (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NAVY Dept.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
13. FATHER'S NAME <u>Charles Biondi</u>					14. MOTHER'S MAIDEN NAME <u>Maude Bates</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>--</u>					16. SOCIAL SECURITY NO. <u>----</u>				
17. INFORMANT <u>Robert J. Biondi</u>					Address <u>138 Birch St. Falls Church, Va.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>4201</u> DUE TO <u>ASHD, HCLVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u></u> DUE TO <u></u> (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hr. 2 yrs</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Protemia, Anemia - cause undetermined</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>7-15, 1965</u> to <u>1-5, 1966</u> , that (I) (we) last saw the deceased alive on <u>1-5, 1966</u> , and that death occurred at <u>9:45 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>S.F. Sengstack M.D.</u>									
22b. DATE SIGNED <u>1-5-66</u>									
22c. PHYSICIAN'S NAME (Type) <u>S.F. Sengstack</u>									
22d. ADDRESS <u>9241 Columbia Blvd. Silver Spring, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>									
23b. DATE THEREOF <u>1/8/66</u>									
23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>									
23d. LOCATION (City, town or county) <u>Prince Georges County, Md.</u> (State) <u>Md.</u>									
24. FUNERAL DIRECTOR <u>2901 14th St. N.W. The S.H. Hines Co. Washington, D.C.</u>									
25a. REC'D BY REGISTRAR <u>JAN 10 1966</u>									
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>									

00840

00887

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3rd Lt. J. H. ...
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00868					00850				
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kenwood Park					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kenwood Park				
c. LENGTH OF STAY IN 1b 55 yrs.					d. STREET ADDRESS 5817 Midhill Street				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5817 Midhill Street					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Jennie Artz			First Middle Last Jennie Artz BOGLEY			4. DATE OF DEATH Month Day Year January 12 19 66			
5. SEX F		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/23/1884		9. AGE (In years last birthday) 81	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Samuel Artz					14. MOTHER'S MAIDEN NAME Emma Stearn				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. Unknown		17. INFORMANT 5817 Address Midhill St. Samuel E. Bogley Kenwood Pk., Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Central Thrombosis DUE TO (c) Central Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 9 days 5 yrs.									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1 Jan, 19 50 to 12 JAN, 19 66, that (I) (we) last saw the deceased alive on 12 Jan 19 66, and that death occurred at 4 P M, from the causes and on the date stated above.									
22a. SIGNATURE A. Richwine					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE 12 Jan 19 66		
22c. PHYSICIAN'S NAME (Type) A. RICHWINE					22d. ADDRESS 522 WESTERN AVE CITY CHASE, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 15 Jan. '66		23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery			23d. LOCATION (City, town or county) (State) Rockville, Md.		
24. FUNERAL DIRECTOR Robert A. Pumphrey					25a. REC'D BY REGISTRAR 1557 ADDRESS Bethesda, Md.		25b. REGISTRAR'S SIGNATURE J. Charles Judge		
					DATE JAN 17 1966				

00650

00650

Central Bureau
Central Bureau

12-10-55
12-10-55
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ATTORNEY GENERAL
ATTORNEY GENERAL

6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

- Cleared with Medical Examiner

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00869						00851					
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>1hr</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>						d. STREET ADDRESS <u>2226 Washington Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Murray</u>			First <u>Murray</u> Middle <u>Bowdan</u> Last <u>Bowdan</u>			4. DATE OF DEATH <u>January 11 1966</u>			Month <u>January</u> Day <u>11</u> Year <u>1966</u>		
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-11-1900</u>		9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New York City, N.Y.</u>				12. CITIZEN OF WHAT COUNTRY? <u>ZUSA</u>	
13. FATHER'S NAME <u>NATHAN BOWDAN</u>						14. MOTHER'S MAIDEN NAME <u>REGINA SCHWALBE</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>110-03-3730</u>		17. INFORMANT <u>Wife: Ethel Bowdan -- Same as</u>		Address <u>above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Occlusion - Coronary Stenosis</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Heart Disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>5 yrs - 15 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Question of Gastric-Intestinal Bleeding on Coumadin</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1959</u> , to <u>11 Jan, 1966</u> , that (I) (we) last saw the deceased alive on <u>10 Jan 1966</u> , and that death occurred at <u>9:50 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Merton L. White</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11 Jan 66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Merton L. White</u>						22d. ADDRESS <u>9911 Georgetown Rd. Falls Church VA.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>1-13-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NATH MEMORIAL PARK</u>			23d. LOCATION (City, town or county) (State) <u>FALLS CHURCH VA.</u>			
24. FUNERAL DIRECTOR <u>Guthrie Funeral Home - 4217-9th St S.W.</u>						ADDRESS		25a. REC'D BY REGISTRAR <u>Jan 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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Handwritten notes, possibly "I" and "J"

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18, give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISM (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00870

00852

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda.</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda. 15-1</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>8111 Custer Rd.</i>				d. STREET ADDRESS <i>8111 Custer Rd.</i>			
3. NAME OF DECEASED (Type or print) First <i>William</i> Middle <i>Edward</i> Last <i>Boyle</i>				4. DATE OF DEATH Month <i>Jan</i> Day <i>21</i> Year <i>1966</i>			
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/2/24</i>	9. AGE (In years last birthday) <i>41</i> yrs.	IF UNDER 1 YEAR Months <i>10</i> Days <i>19</i>	IF UNDER 24 HRS. Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Smithsonian Institute</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Administrator</i>		11. BIRTHPLACE (State or foreign country) <i>Washington DC.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>OHion Boyle</i>				14. MOTHER'S MAIDEN NAME <i>Ida - Reckeweg</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>Yes WW II</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT <i>Wife - Barbara B. Boyle</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>AS Ph 422 - from Hanging</i> 974X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i></i> DUE TO (c) <i></i>						INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Hung self by rope tied to rafters in garage</i>					
20c. TIME OF INJURY Month, Day, Year <i>1st Hour 1/21 1966</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) (County) (State) <i>Bethesda. Montgomery Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John G. Ball</i>		22. DATE SIGNED <i>1/21/66</i>					
EXAMINER'S NAME (Type) <i>JOHN G. BALL</i>		Address (Street, city, town, or county) <i>Bethesda, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>1-24-66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>		23d. LOCATION (City, town or county) (State) <i>Suitland, Maryland</i>	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY</i>				25a. REC'D BY REGISTRAR <i>JAN 26 1966</i>			
				25b. REGISTRAR'S SIGNATURE <i>John G. Ball</i>			

1870

[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a multi-paragraph document, possibly a letter or a report, with some lines of text visible in the upper and lower portions.]

[Faint text at the top of the page, possibly a header or address.]

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[Faint text at the bottom of the page, possibly a signature or footer.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00871					00853						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)						
a. COUNTY MONTGOMERY					a. STATE MARYLAND						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK					b. COUNTY PRINCE GEORGES						
c. LENGTH OF STAY IN 1b 8 days					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SANITARIUM & HOSPITAL					d. STREET ADDRESS 9210 25th Place.						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First ANNA			Middle ELIZABETH			Last BRIDGES			4. DATE OF DEATH Month JANUARY		
5. SEX Female			6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 25 1885		9. AGE (In years last birthday) 80 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE-SALESLADY			10b. KIND OF BUSINESS OR INDUSTRY SALES			11. BIRTHPLACE (County & State, or foreign country) West VIRGINIA			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Whalen					14. MOTHER'S MAIDEN NAME ?						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO					16. SOCIAL SECURITY NO.		17. INFORMANT PATIENT'S CHART				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis (c) Atherosclerotic Cardiovascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid Arthritis, Bronchiectasis					INTERVAL BETWEEN ONSET AND DEATH 8 days 1 year 10 years					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. TIME OF INJURY Hour a.m. p.m.			20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20d. (City or town) (County) (State)		
20e. (City or town)			20f. (County)			20g. (State)					
21. I certify that (I) (this hospital) attended the deceased from June, 1966, to Jan, 1966, that (I) (we) last saw the deceased alive on Jan 19 1966, and that death occurred at 10:30 PM, from the causes and on the date stated above.											
22a. SIGNATURE Thomas P. Fogarty					22b. DATE SIGNED Jan 19 1966						
22c. PHYSICIAN'S NAME (Type) THOMAS P. FOGARTY					22d. ADDRESS 1011 University Blvd E. Sil Sp. Md						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Jan 13, 1966			23c. NAME OF CEMETERY OR CREMATORY Date of Heaven			23d. LOCATION (City, town or county) (State) Montgomery Co. Md		
24. FUNERAL DIRECTOR Arthur Willets					25a. REC'D BY REGISTRAR JAN 13 1966					25b. REGISTRAR'S SIGNATURE Charles Judge	

0023

00871



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00872

00854

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 120 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Tennessee b. COUNTY Martin c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 79-3 d. STREET ADDRESS 214 Summer Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Tabitha (None) Brooks		4. DATE OF DEATH January 28, 19 66		5. SEX Female	
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 21 January 1901	
9. AGE (In years last birthday) 65 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Representative		11. BIRTHPLACE (County & State, or foreign country) Tennessee	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Benjamin Franklin Howell		14. MOTHER'S MAIDEN NAME Dora Elizabeth Morgan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 414-30-2206		17. INFORMANT The Medical Record, The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal Hemorrhage 205X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple ulcerations of esophagus and stomach DUE TO (c) Mycosis fungoides, diffuse involvement					INTERVAL BETWEEN ONSET AND DEATH 2 days 1 month 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 30, 19 65 , to Jan. 28, 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Jan. 28, 19 66 , and that death occurred at 7:40 M. from the causes and on the date stated above.					
22a. SIGNATURE Harley A. Haynes		22b. DATE SIGNED 28 Jan. 1966		22c. PHYSICIAN'S NAME (Type) Harley A. Haynes, M.D.	
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.		22e. REC'D BY REGISTRAR FEB 4 1966			
22f. REGISTRAR'S SIGNATURE Charles Judge		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF 1/31/66		23c. NAME OF CEMETERY OR CREMATORY East Side		23d. LOCATION (City, town or county) (State) Martin, Tennessee	
24. FUNERAL DIRECTOR Robert A. Pumphrey		25. ADDRESS 7557 Wisconsin Ave., Bethesda, Md.			

00873

Reception

Admission

The patient was admitted to the hospital on 10/10/50.

History (Present Illness) - The patient is a 45-year-old male.

Personal History - The patient has no significant past medical history.

Family History - There is no family history of similar illness.

Physical Examination - On admission, the patient was found to be

in good health. The physical examination was within normal limits.

Investigations - Laboratory tests showed normal results.

Diagnosis - The patient was diagnosed with a mild case of

hypertension. The patient was advised to maintain a healthy diet.

X

September 30, 1950

7740

Admission

The patient was found to be in good health. The physical examination was within normal limits.

History A. History of the present illness.

Physical Examination

Investigations

Diagnosis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00873						00855					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY <i>Montgomery</i>			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>			c. LENGTH OF STAY IN 1b <i>34 days</i>			d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Cedar Haven Rest Home</i>		
a. STATE <i>Maryland</i>			b. COUNTY <i>Montgomery</i>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring 15-1</i>			d. STREET ADDRESS <i>103 Fleetwood Terrace</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <i>BERTHA A. GERTRUDE BROWN</i>			4. DATE OF DEATH <i>JAN 21 1966</i>								
5. SEX <i>F.</i>			6. COLOR OR RACE <i>W.</i>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <i>July 10, 1892</i>		
9. AGE (in years last birthday) <i>73</i>			IF UNDER 1 YEAR Months Days Hours Min.			IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sales lady</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Department Store</i>			11. BIRTHPLACE (County & State, or foreign country) <i>Washington, DC</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Joseph Clements</i>						14. MOTHER'S MAIDEN NAME <i>McCaulley</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>						16. SOCIAL SECURITY NO. <i></i>					
17. INFORMANT <i>Mrs. Agnes Rippeon</i>						Address <i>103 Fleetwood Ave S.S.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Yellow Cancer of Colon</i>											
1538 DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cancer of PT Ovary</i>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <i>11/1/50</i> , 19 <i>50</i> , to <i>1/21</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>1/21</i> 19 <i>65</i> , and that death occurred at <i>12</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>A.C. LEONARDO</i>											
22b. DATE SIGNED <i>1/21/66</i>											
22c. PHYSICIAN'S NAME (Type) <i>A.C. LEONARDO</i>											
22d. ADDRESS <i>15801-13th St NW Wash DC</i>											
22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>											
23b. DATE THEREOF <i>JAN. 24 1966</i>											
23c. NAME OF CEMETERY OR CREMATORY <i>Mount Olivet Cemetery</i>											
23d. LOCATION (City, town or county) (State) <i>Washington, DC</i>											
24. FUNERAL DIRECTOR <i>Arthur Kallas</i>											
ADDRESS <i>254 Carroll Rd NW Wash DC</i>											
25a. REG'D BY REGISTRAR <i>JAN 24 1966</i>											
25b. REGISTRAR'S SIGNATURE <i>John Charles Judge</i>											

MEDICAL CERTIFICATION

00873

00873

ORIGINAL

1966 / *[Signature]*

1. Name of Deceased: [illegible]
2. Date of Death: [illegible]
3. Place of Death: [illegible]
4. Age: [illegible]
5. Sex: [illegible]
6. Race: [illegible]
7. Occupation: [illegible]
8. Marital Status: [illegible]
9. Education: [illegible]
10. Religion: [illegible]
11. Usual Residence: [illegible]
12. Date of Birth: [illegible]
13. Social Security Number: [illegible]
14. Date of Admission: [illegible]
15. Date of Discharge: [illegible]
16. Date of Death: [illegible]
17. Cause of Death: [illegible]
18. Manner of Death: [illegible]
19. Signature of Examiner: [illegible]
20. Date of Report: [illegible]

21. Name of Physician: [illegible]
22. Date of Examination: [illegible]
23. Place of Examination: [illegible]
24. Age: [illegible]
25. Sex: [illegible]
26. Race: [illegible]
27. Occupation: [illegible]
28. Marital Status: [illegible]
29. Education: [illegible]
30. Religion: [illegible]
31. Usual Residence: [illegible]
32. Date of Birth: [illegible]
33. Social Security Number: [illegible]
34. Date of Admission: [illegible]
35. Date of Discharge: [illegible]
36. Date of Death: [illegible]
37. Cause of Death: [illegible]
38. Manner of Death: [illegible]
39. Signature of Examiner: [illegible]
40. Date of Report: [illegible]

41. Name of Physician: [illegible]
42. Date of Examination: [illegible]
43. Place of Examination: [illegible]
44. Age: [illegible]
45. Sex: [illegible]
46. Race: [illegible]
47. Occupation: [illegible]
48. Marital Status: [illegible]
49. Education: [illegible]
50. Religion: [illegible]
51. Usual Residence: [illegible]
52. Date of Birth: [illegible]
53. Social Security Number: [illegible]
54. Date of Admission: [illegible]
55. Date of Discharge: [illegible]
56. Date of Death: [illegible]
57. Cause of Death: [illegible]
58. Manner of Death: [illegible]
59. Signature of Examiner: [illegible]
60. Date of Report: [illegible]

61. Name of Physician: [illegible]
62. Date of Examination: [illegible]
63. Place of Examination: [illegible]
64. Age: [illegible]
65. Sex: [illegible]
66. Race: [illegible]
67. Occupation: [illegible]
68. Marital Status: [illegible]
69. Education: [illegible]
70. Religion: [illegible]
71. Usual Residence: [illegible]
72. Date of Birth: [illegible]
73. Social Security Number: [illegible]
74. Date of Admission: [illegible]
75. Date of Discharge: [illegible]
76. Date of Death: [illegible]
77. Cause of Death: [illegible]
78. Manner of Death: [illegible]
79. Signature of Examiner: [illegible]
80. Date of Report: [illegible]

81. Name of Physician: [illegible]
82. Date of Examination: [illegible]
83. Place of Examination: [illegible]
84. Age: [illegible]
85. Sex: [illegible]
86. Race: [illegible]
87. Occupation: [illegible]
88. Marital Status: [illegible]
89. Education: [illegible]
90. Religion: [illegible]
91. Usual Residence: [illegible]
92. Date of Birth: [illegible]
93. Social Security Number: [illegible]
94. Date of Admission: [illegible]
95. Date of Discharge: [illegible]
96. Date of Death: [illegible]
97. Cause of Death: [illegible]
98. Manner of Death: [illegible]
99. Signature of Examiner: [illegible]
100. Date of Report: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div style="display: flex; justify-content: space-between;"> <div> <p>7-31</p> <p>4</p> </div> <div> <p>7-31</p> <p>4</p> </div> </div> <div style="text-align: center;"> <p>7-31</p> <p>4</p> </div>											
<p style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </p>											
<p>1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND</p>				<p>2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>mont.</i></p>							
<p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i></p>				<p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i></p>				<p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Suburban</i></p>			
<p>3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>Raymond</i> Last <i>Buchanan</i></p>				<p>4. DATE OF DEATH Month <i>1</i> Day <i>6</i> Year <i>1966</i></p>				<p>5. SEX <i>m</i> 6. COLOR OR RACE <i>Gr</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>			
<p>8. DATE OF BIRTH <i>10/27/94</i></p>				<p>9. AGE (In years last birthday) <i>71</i> yrs.</p>				<p>10. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS. <input type="checkbox"/></p>			
<p>11. BIRTH PLACE (County & State, or foreign country) <i>Maryland</i></p>				<p>12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i></p>				<p>13. FATHER'S NAME <i>John M. Buchanan</i></p>			
<p>14. MOTHER'S MAIDEN NAME <i>Pauline Core</i></p>				<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> (If yes give war or dates of service) <i>WW2 - Army</i></p>				<p>16. SOCIAL SECURITY NO. <i>Unobtainable</i></p>			
<p>17. INFORMANT <i>Gertrude C. Buchanan</i></p>				<p>18. ADDRESS <i>Same as above</i></p>				<p>19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> (c) <i>Cardiac Decompensation - Chronic Nephritis</i></p>			
<p>20. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i></p>				<p>21. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p>				<p>22. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>			
<p>23. (City or town) (County) (State)</p>				<p>24. I certify that (I) (this hospital) attended the deceased from <i>1/6</i>, 19<i>66</i>, to <i>1/6</i>, 19<i>66</i>, that (I) (we) last saw the deceased alive on <i>1/6</i>, 19<i>66</i>, and that death occurred at <i>1 P.M.</i> from the causes and on the date stated above.</p>				<p>25. DATE SIGNED <i>1-6-66</i></p>			
<p>26. SIGNATURE <i>William D. And</i></p>				<p>27. PHYSICIAN'S NAME (Type) <i>William D. And</i></p>				<p>28. ADDRESS <i>9006 Colesville Rd., S. S., Md.</i></p>			
<p>29. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i></p>				<p>30. DATE THEREOF <i>1-11-66</i></p>				<p>31. NAME OF CEMETERY OR CREMATORY <i>Arlington Nat'l Cemetery</i></p>			
<p>32. LOCATION (City, town or county) (State) <i>Arlington, Virginia</i></p>				<p>33. REC'D BY REGISTRAR <i>Charles Judge</i></p>				<p>34. REGISTRAR'S SIGNATURE <i>Charles Judge</i></p>			
<p>35. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i></p>				<p>36. ADDRESS <i>8434 Georgia Avenue, Silver Spring, Md.</i></p>				<p>37. DATE <i>JAN 13 1966</i></p>			

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00876

00858

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 15-1	
c. LENGTH OF STAY IN 1b 1 day		d. STREET ADDRESS 8484 - 16th Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Congressional Manor Sanitarium		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle B. Last BUCKMAN		4. DATE OF DEATH Month Jan. Day 23, Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 19, 1882
9. AGE (In years last birthday) 83 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Shipping Board	11. BIRTHPLACE (State or foreign country) North Carolina
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Shipping Board		10b. KIND OF BUSINESS OR INDUSTRY Maritime	12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME Samuel A. Buckman		14. MOTHER'S MAIDEN NAME Eva Martin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Wife		Address Elizabeth K. Buckman Same as Item 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Cardio-vascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH Sudden years
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John G. Ball		22. DATE SIGNED 1-23-66	
EXAMINER'S NAME (Type) JOHN G. BALL		Address (Street, city, town, or county) Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/25/66	23c. NAME OF CEMETERY OR CREMATORY Louden Park	23d. LOCATION (City, town or county) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Robert A. Pumphrey		25a. REC'D BY REGISTRAR Jan 26 1966	
ADDRESS Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 7/61

MAYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00877					00859				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)				
a. COUNTY		MONTGOMERY			a. STATE		WISCONSIN		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		BETHESDA			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		DELA FIELD 86-3		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		7601 CARTER COURT			d. STREET ADDRESS		409 ANDERSON DR.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First		Middle		Last		Month		Day	
STEPHEN EARL		BULLMAN		JAN.		6		1966	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
M		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11-21-1894		71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
RET. OFFICER		U.S. ARMY		ILLINOIS		U.S. A.			
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
STEPHEN BULLMAN					(UNKNOWN) CHURCH				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)					16. SOCIAL SECURITY NO.				
YES RET. 1954					393-07-5466				
17. INFORMANT					Address				
Mrs. ELVIRA BULLMAN									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:								4 hrs	
IMMEDIATE CAUSE (a) HEPATIC FAILURE									
1538 DUE TO Carcinoma Colon-								2 yrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year								20d. INJURY OCCURRED	
Hour a.m. p.m. 19								While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)								20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 1965 to 1/6, 1966; that (I) (we) last saw the deceased alive on Jan 6, 1966, and that death occurred at 5 P.M. from the causes and on the date stated above.									
22a. SIGNATURE								22b. DATE	
Horace W. Perinton M.D.								Jan 6, 1966	
22c. PHYSICIAN'S NAME (Type)								22d. ADDRESS	
HORACE W. PERINTON, MD								4343 BRIDLE BLVD, BETH, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify)								23b. DATE THEREOF	
Burial 11-11-66								23c. NAME OF CEMETERY OR CREMATORY	
Arlington National								23d. LOCATION (City, town or county) (State)	
Arlington VA.									
24. FUNERAL DIRECTOR'S SIGNATURE								25a. REC'D BY REGISTRAR	
Vincent J. Tuncap Home, 760 Georgia Ave N.W. DC								25b. REGISTRAR'S SIGNATURE	
JAN 11 1966								Charles Judge	

00877

00877

WISCONSIN

WISCONSIN

DELA FIELD

4 WEEKS

BETHESDA

1001 CHURCH COURT

1001 CHURCH COURT

11-21-1914

11-21-1914

U.S.A.

ILLINOIS

U.S. ARMY

RET. OFFICER

CHURCH

BULLMAN

STEPHEN

28-10-1914

28-10-1914

11-21-1914

11-21-1914

11-21-1914

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11-21-1914

Signed with knowledge Dr. B. R. Pugh
Induced abortion.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
00878					00860					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY		Montgomery			a. STATE		b. COUNTY			
		MARYLAND					Maryland			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					
Silver Spring					Silver Spring		15-1			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?		
11804 Indigo Road					11804 Indigo Road			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		
		Maria		Caponiti				Month Day Year		
								January 24 19 66		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		13 August 1889		76 yrs.		
								IF UNDER 1 YEAR IF UNDER 24 HRS.		
								Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?				
housewife				Italy		U.S.				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
Giovanni Briguglio					Santa Rigano					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT		Address				
No				Natale Caponiti, 1 d above						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Acute Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary insufficiency. (c) Arterio-sclerotic heart disease								INTERVAL BETWEEN ONSET AND DEATH Sudden 1 yr. 7 yrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 7/1/50, 19 to 1-24, 1966, that (I) (we) last saw the deceased alive on 12/26 1965, and that death occurred at 5:47 M, from the causes and on the date stated above.										
22a. SIGNATURE Francis X. Richardson					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/24/66	
22c. PHYSICIAN'S NAME (Type) Francis X. Richardson, M.D.					22d. ADDRESS 11412 Viers Mill Road Wheaton, Maryland 20902					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)				
Burial		27 Jan. 1966		Cedar Hill Mausoleum		Suitland, Md.				
24. FUNERAL DIRECTOR Rinaldi Funeral Home 7400 Georgia Ave., NW					ADDRESS DC 20012		25a. REC'D BY REGISTRAR DATE JAN 26 1966		25b. REGISTRAR'S SIGNATURE John J. Judge	

CERTIFICATE OF DEATH

1917

Form with multiple sections for recording death statistics, including fields for name, age, sex, race, cause of death, and place of death. The form is oriented horizontally but contains vertical text labels for various categories.

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
CAUSE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
DATE OF DEATH: [illegible]
SIGNATURE: [illegible]
OFFICIAL: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #23a, b, c & d Film #G373 2/11/66 pc

00879

CERTIFICATE OF DEATH

00861

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Va.</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Springfield 23-3</u> d. STREET ADDRESS <u>6734 Bowie Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Elizabeth Rose Caputo</u> First Middle Last 5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			4. DATE OF DEATH <u>1/31</u> Month Day Year <u>1966</u> 8. DATE OF BIRTH <u>11/2/23</u> 9. AGE (In years last birthday) <u>42</u> yrs. 10. UNDER 1 YEAR Months Days 10. UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Wash DC</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Fred - Zegowitz</u> 14. MOTHER'S MAIDEN NAME <u>Rose Wellborn</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. <u>577-20-7933</u> 17. INFORMANT <u>Husband - Eugene</u> Address <u>Same as above</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DIABETIC NEPHROPATHY</u> DUE TO (c) <u>HYPERTENSIVE HEART DISEASE WITH</u> <u>Constrictive Heart failure</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 29</u> , 19 <u>66</u> , to <u>Jan 31</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Jan 29</u> , 19 <u>66</u> , and that death occurred at <u>2:45</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>R. Hammond MISH</u> 22c. PHYSICIAN'S NAME (Type) <u>R. HAMMOND MISH</u>			22b. DATE SIGNED <u>1-31-66</u> 22d. ADDRESS <u>3800 Jenks St NW</u>		22e. M.D. ATTENDING PHYS. <input type="checkbox"/> 22f. MED. DIRECTOR <input type="checkbox"/> 22g. STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/4/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>			
23d. LOCATION (City or Town) (County) (State) <u>Arlington, Va.</u>		24. FUNERAL DIRECTOR <u>Carington Martin Linnard</u> ADDRESS <u>6161 Leesburg Pike Falls Church, Va.</u>					
25a. REC'D BY REGISTRAR <u>FEB 7 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10200

00623

TO THE DIRECTOR, BUREAU OF THE
LAND OFFICE, WASHINGTON, D. C.
FROM THE COMMISSIONER, LAND OFFICE,
ALABAMA

CERTIFICATE OF DEATH

Reg. Dist. No. 00862

00880

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington 15-1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9809 Connecticut Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MABEL Middle G. Last CARPENTER				4. DATE OF DEATH Month January Day 3 Year 19 66			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2, 1906	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months 2 Days 1	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Education		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Claude N. Rider				14. MOTHER'S MAIDEN NAME Bertha Hury			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		INFORMANT M. Michael Carpenter, 9809 Connecticut Ave., Kensington, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma 2001 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Nephrotic Syndrome						INTERVAL BETWEEN ONSET AND DEATH 18 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/11/64 , 19___, to 1/3/66 , 19___, that I last saw the deceased alive on 1/2/66 , 19___, and that death occurred at 4:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Henry C. Scruggs				DATE SIGNED 5413 Cedar Lane Bethesda Md 1/3/66			
PHYSICIAN'S NAME (Type) HENRY C. SCRUGGS M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 5, 1966		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				24a. REC'D BY REGISTRAR JAN 6 1966		24b. REGISTRAR'S SIGNATURE Charles Judge	

VS A15 (4)
ISM 9/58

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1988

CERTIFICATE OF DEATH

1988

1. Name of deceased: _____

2. Sex: _____

3. Date of birth: _____

4. Place of birth: _____

5. Date of death: _____

6. Place of death: _____

7. Cause of death: _____

8. Signature of physician: _____

9. Signature of registrar: _____

10. Date of registration: _____

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

<div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>00881</div> <div>00863</div> </div> <div> <div>Items 18&21 Film G373 2/14/66 TT</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> </div> </div>											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash San. & Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Creek Ch. Rd. Dupont</u> d. STREET ADDRESS <u>SOLDIER'S HOME</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Carroll</u> Last <u>Carroll</u>				4. DATE OF DEATH Day <u>17</u> Month <u>1</u> Year <u>1966</u>				5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Apr 9-08</u> 9. AGE (In years last birthday) <u>57</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SOLDIER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u> </u> 11. BIRTHPLACE (State or foreign country) <u>USA</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Andy Carroll</u> 14. MOTHER'S MAIDEN NAME <u>Mattie Martha Phillips</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>WW II, Korea</u> 16. SOCIAL SECURITY NO. <u>406-34-2932</u> 17. INFORMANT <u>Records, U. S. Soldiers' Home</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive intrapontine hemorrhage.</u> (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Belden R. Reap M.D.</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED <u>1-17-1966</u> EXAMINER'S NAME (Type) <u>BELOEN R. REAP M.D.</u> Address (Street, city, town, or county) <u> </u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>23 January 1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Soldiers' Home Natl.</u> 23d. LOCATION (City, town or county) (State) <u>Washington D. C.</u>											
24. FUNERAL DIRECTOR <u>Daniel J. McAmis</u> ADDRESS <u>U. S. Soldiers' Home Washington, D. C.</u> 25a. REC'D BY REGISTRAR <u>JAN 20 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											

00803

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00803

THE STATE OF NEW YORK
COUNTY OF []

John (Rock) CHAY, 47 years
of age, died on [] at []

John (Rock) CHAY

John (Rock) CHAY

John (Rock) CHAY, 47 years

John (Rock) CHAY, 47 years

John (Rock) CHAY, 47 years

John (Rock) CHAY, 47 years

John (Rock) CHAY, 47 years

John (Rock) CHAY, 47 years

John (Rock) CHAY, 47 years

John (Rock) CHAY, 47 years

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Wheaton c. LENGTH OF STAY IN 1b 3 months d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) University Nursing Home				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 103 Eastmoor Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Thomas First (none) Middle CARROLL Last				4. DATE OF DEATH Jan. Month 12 Day 1966 Year							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/30/1912		9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months 14 Days 14 Hours 14 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate Salesman				10b. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (County & State, or foreign country) Glenmont, Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Thomas Carroll Sr.				14. MOTHER'S MAIDEN NAME Sarah Connelly							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 578-38-5309		17. INFORMANT Mrs. Austin D. Banda		Address 10111 Mc Kenney Ave. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Hemorrhage. 1538 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic carcinoma of colon. 8 months. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 3 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Antibiotic Heart Disease.										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 12, 1963 to Jan 12, 1966, that (I) (we) last saw the deceased alive on Jan 10, 1966, and that death occurred at 11:30 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Seruch T. Kimble				22b. DATE SIGNED 1-12-66							
22c. PHYSICIAN'S NAME (Type) /Seruch Kimble				22d. ADDRESS 2774 Rocking Horse Lane, Silver Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 1-15-66		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City, town or county) (State) Rockville, Maryland			
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.				ADDRESS 8434 Georgia Avenue Silver Spring, Md.				25a. REC'D BY REGISTRAR Jan 17 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

00882

10000

DEATH

DATE

TIME

PLACE

CAUSE

AGE

SEX

RELATIONSHIP

REMARKS

SIGNATURE

DATE

TIME

PLACE

CAUSE

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SEX

RELATIONSHIP

REMARKS

SIGNATURE

DATE

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CAUSE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>1</div> <div>00883</div> <div>00865</div>											
<div>1. PLACE OF DEATH</div> <div>e. COUNTY</div> <div>Montgomery</div> <div>MARYLAND</div> <div>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>Silver Spring</div> <div>c. LENGTH OF STAY IN 1b</div> <div>1 hr.</div> <div>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)</div> <div>Holy Cross Hospital</div>											
<div>2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)</div> <div>e. STATE</div> <div>Maryland</div> <div>b. COUNTY</div> <div>Montgomery</div> <div>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>Kensington</div> <div>15-1</div> <div>d. STREET ADDRESS</div> <div>2807 Jennings Road</div> <div>e. IS RESIDENCE ON A FARM?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>											
<div>3. NAME OF DECEASED (Type or print)</div> <div>First</div> <div>Manuel</div> <div>Middle</div> <div></div> <div>Last</div> <div>Casares, Sr</div> <div>4. DATE OF DEATH</div> <div>Month</div> <div>Jan.</div> <div>Day</div> <div>25</div> <div>Year</div> <div>1966</div>											
<div>5. SEX</div> <div>male</div> <div>6. COLOR OR RACE</div> <div>white</div> <div>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> <div>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div> <div>8. DATE OF BIRTH</div> <div>7/29/99</div> <div>9. AGE (In years last birthday)</div> <div>66 yrs.</div> <div>IF UNDER 1 YEAR</div> <div>Months</div> <div>Days</div> <div>Hours</div> <div>Min.</div>											
<div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>Foreign Correspondent-Spanish Embassy</div> <div>10b. KIND OF BUSINESS OR INDUSTRY</div> <div>Spain</div> <div>11. BIRTHPLACE (County & State, or foreign country)</div> <div>Spain</div> <div>12. CITIZEN OF WHAT COUNTRY?</div> <div>Spain</div>											
<div>13. FATHER'S NAME</div> <div>Francisco Casares</div> <div>14. MOTHER'S MAIDEN NAME</div> <div>Anna Sanchez</div>											
<div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)</div> <div>no</div> <div>16. SOCIAL SECURITY NO.</div> <div>none</div> <div>17. INFORMANT</div> <div>Manuel Casares, Jr.</div> <div>Address</div> <div>7911 Kreeger Dr. Adelphi, Md.</div>											
<div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a)</div> <div>1621</div> <div>Cardiovascular Collapse</div> <div>DUE TO</div> <div>(b)</div> <div>BRONCHOGENIC CARCINOMA, LUNG</div> <div>DUE TO</div> <div>(c)</div> <div>INTERVAL BETWEEN ONSET AND DEATH</div> <div>2 HOURS</div> <div>1 YEAR</div>											
<div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</div> <div>19. WAS AUTOPSY PERFORMED?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>											
<div>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)</div> <div>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</div>											
<div>20c. TIME OF INJURY</div> <div>Month, Day, Year</div> <div>Hour e.m.</div> <div>p.m.</div> <div>19</div> <div>20d. INJURY OCCURRED</div> <div>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></div> <div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div> <div>20f. (City or town)</div> <div>(County)</div> <div>(State)</div>											
<div>21. I certify that (I) (this hospital) attended the deceased from 1/5, 1966, to 1/25, 1966, that (I) (we) last saw the deceased alive on 1/5, 1966, and that death occurred at 12:30 P.M. from the causes and on the date stated above.</div>											
<div>22a. SIGNATURE</div> <div>Paul Schlein</div> <div>M.D.</div> <div>ATTENDING PHYS.</div> <div><input checked="" type="checkbox"/></div> <div>MED. DIRECTOR <input type="checkbox"/></div> <div>STAFF PHYS.</div> <div><input type="checkbox"/></div> <div>22b. DATE SIGNED</div> <div>1/25/66</div>											
<div>22c. PHYSICIAN'S NAME (Type)</div> <div>Paul Schlein</div> <div>M.D.</div> <div>22d. ADDRESS</div> <div>730 24th St. N.W. Wash D.C.</div>											
<div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>burial</div> <div>23b. DATE THEREOF</div> <div>1/27/66</div> <div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>Gate of Heaven Cem.</div> <div>23d. LOCATION (City, town or county)</div> <div>Montgomery Co.</div> <div>(State)</div> <div>Md.</div>											
<div>24. FUNERAL DIRECTOR'S SIGNATURE</div> <div>The S.H. Hines Co.</div> <div>ADDRESS</div> <div>Washington, D.C.</div> <div>25a. REC'D BY REGISTRAR</div> <div>JAN 28 1966</div> <div>25b. REGISTRAR'S SIGNATURE</div> <div>Charles Judge</div>											

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Montgomery

Montgomery

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00884

00866

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>14 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CEDAR HAVEN Rest Home</u> <u>4300 BALTIMORE AVE Takoma Park</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>9415 WIRE AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>DANIEL Cayelli</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>13</u> Year <u>1966</u>		5. SEX <u>M</u>			
6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Aug 26, 1878</u>		9. AGE (In years last birthday) <u>87</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Store</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u>			
13. FATHER'S NAME <u>Ferdinand Cayelli</u>		14. MOTHER'S MAIDEN NAME <u>Madehina Sherrini</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Charles Cayelli</u> Address <u>9415 WIRE AVE SILVER SPRING</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Cystitis & Prostatitis</u> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Status Post-op Fracture Hip</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Stumbled on Rug at Home</u> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Month, Day, Year <u>3:00 p.m. Dec 25, 1966</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 25, 1966</u> , to <u>Jan 13, 1966</u> , that (I) (we) last saw the deceased alive on <u>Jan 13, 1966</u> , and that death occurred at <u>1:00 P.M.</u> from the causes and on the date stated above.		20f. (City or town) <u>Silver Spring</u> (County) <u>Mont.</u> (State) <u>Md.</u>		22b. DATE SIGNED <u>JAN 14, 1966</u>			
22a. SIGNATURE <u>Richard J. Cavanaugh</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS <u>1015 Spring St. Silver Spring</u>			
22c. PHYSICIAN'S NAME (Type) <u>Richard J. Cavanaugh, M.D.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Jan-17-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>St. Agnes Conv.</u> 23d. LOCATION (City, town or county) <u>Montgomery</u> (State) <u>Penn.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

00885

00867

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs 16-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium</u>		e. STREET ADDRESS <u>8500 New Hampshire ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Samuel Chaikin</u>		4. DATE OF DEATH <u>Jan 31 1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-30-1899</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk - lig. store</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LIQUOR</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Max Chaikin</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Kay</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>579-201932</u>	
17. INFORMANT <u>Mrs. Pauline Chaikin</u>		Address <u>8500 New Hampshire Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiorespiratory failure accompanied</u> 582X DUE TO (b) <u>by multiple liver abscesses and generalized</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c) <u>amyloidosis.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		22. DATE SIGNED <u>1-31-1966</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Washington D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>2-2-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ONEVITHOLOM CEM.</u>	23d. LOCATION (City, town or county) (State) <u>WASHINGTON D.C.</u>
24. FUNERAL DIRECTOR <u>CONDORGE FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>FEB 7 1966</u>	
ADDRESS <u>4217 9TH ST. N.W.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00887

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00887

THE STATE

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1-21-1968

1968

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00886

00868

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montg,</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> <u>15-1</u> d. STREET ADDRESS <u>21 Brooks. Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Maurice</u> <u>Hershberger</u> <u>Chiswell</u> First Middle Last				4. DATE OF DEATH <u>Jan 17th</u> <u>1966</u> Month Day Year					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 22-19 1896</u>		9. AGE (In years last birthday) <u>69</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired. Clerk.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>III</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Dickerson. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Lawrence A. Chiswell</u>				14. MOTHER'S MAIDEN NAME <u>Hattie Hershberger</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>W.W.I.</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-01-6826</u>		17. INFORMANT <u>Marjorie Waters Chiswell. As #2</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart</u> <u>4200</u> DUE TO <u>Disease - AS manifest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>by Congestive Heart</u> Failure (c) <u>etc</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1. Emphysema 2. Tracheo-Bronchitis</u>								INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1-15-66</u> to <u>1-17-66</u> that (I) (we) last saw the deceased alive on <u>1-16-66</u> and that death occurred at <u>11:00</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Jack Schumacher</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-17-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Jack Schumacher *Md. M. D.</u>				22d. ADDRESS <u>Gaithersburg. Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-19-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>		23d. LOCATION (City, town or county) (State) <u>Beallsville. Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner. Gaithersburg. Md.</u>				25a. REC'D BY REGISTRAR <u>JAN 21 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

83206

CENTROST OF BAY

03800

TO RECORD OF VARIOUS DOCUMENTS
IN THE OFFICE OF THE
SECRETARY OF THE
NAVY
AT
WASHINGTON
D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

00887

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00869

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Laytonsville c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Goshen Road				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Laytonsville 15-1 d. STREET ADDRESS Goshen Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Luther First Claggett Last		4. DATE OF DEATH January 28, 1966 Month January Day 28 Year 1966					
5. SEX M	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1907	9. AGE (in years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland			
13. FATHER'S NAME Luther Claggett			14. MOTHER'S MAIDEN NAME Mollie Diggs				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Degenerative Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH Minutes Years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 1-19-66 to 1-28-66 , that (I) (we) last saw the deceased alive on 1-25-66 , and that death occurred at 11:00 M, from the causes and on the date stated above.							
22a. SIGNATURE Jack Shumacher				22b. DATE SIGNED 2-1-66			
22c. PHYSICIAN'S NAME (Type) Ja ck Shumacher				22d. ADDRESS 105n Russell Ave, Gaithersburg Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/1/66		23c. NAME OF CEMETERY OR CREMATORY Brooke Grove Cem.			
				23d. LOCATION (City, town or county) (State) Laytonsville, Md.			
24. FUNERAL DIRECTOR Robert L. Snowden ADDRESS Rockville, Md.				25a. REC'D BY REGISTRAR FEB 7 1966 25b. REGISTRAR'S SIGNATURE Charles Judge			

03200

03800

STATE OF TEXAS

CERTIFICATE OF DEATH

FILE NO. 12345

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

GRANDCHILDREN

ESTATE

DEBTS

ASSETS

LIABILITIES

NET WORTH

DATE OF VALUATION

VALUATOR

NOTARY PUBLIC

COMMISSION EXPIRES

STATE OF TEXAS

CERTIFICATE OF DEATH

FILE NO. 12345

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00888 CERTIFICATE OF DEATH 00870									
1. PLACE OF DEATH a. CDUNITY Montgomery					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Olney			c. LENGTH OF STAY IN 1b -1 DAY		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Germantown			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montgomery General Hospital					d. STREET ADDRESS 23001 Ridge Rd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edith		First MAE		Last Clark		4. DATE OF DEATH Jan. 7 1966		Day 7 Year 1966	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-7-84		9. AGE (In years last birthday) 81 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (County & State, or foreign country) Virginia.			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Berman					14. MOTHER'S MAIDEN NAME Anne M. Guyon				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. 215-57-3037		17. INFORMANT HOSPITAL RECORDS & FAMILY				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 2041 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Thrombocytopenia DUE TO (c) Chronic myelogenous leukemia			INTERVAL BETWEEN ONSET AND DEATH 4 mos.						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Jan. 6, 1966 , to Jan. 7, 1966 , that (I) (we) last saw the deceased alive on Jan 6 1966 , and that death occurred at 350 AM , from the causes and on the date stated above.									
22a. SIGNATURE Fredrick Mooman					M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Jan. 7, 1966		
22c. PHYSICIAN'S NAME (Type) Dr. Mooman					22d. ADDRESS SANDY SPRING, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 1/10/66		23c. NAME OF CEMETERY OR CREMATORY Linden Park Cem		23d. LOCATION (City, town or county) (State) Linden, N.J.		
24. FUNERAL DIRECTOR W. W. CHAMBERS, INC. SIL. SP. MD.					ADDRESS SIL. SP. MD.		25a. REC'D BY REGISTRAR JAN 13 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge

0088

0088

THE STATE OF TEXAS

County of _____
I, _____
do hereby certify that _____
is the true and correct _____
of the _____

Witness my hand and seal this _____ day of _____
19____

Notary Public in and for the State of Texas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

00889

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00871

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		d. STREET ADDRESS <u>7217 Spruce Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SANITARIUM & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Sophie</u> Middle <u>May</u> Last <u>Cole</u>		4. DATE OF DEATH Month <u>JANUARY</u> Day <u>9</u> Year <u>1966</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-22-1885</u>		9. AGE (In years last birthday) <u>80 yrs.</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES PERKINS</u>				14. MOTHER'S MAIDEN NAME <u>CORNELIA THOMAS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>PATIENT'S CHART</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>4221</u> DUE TO <u>Cardiovascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO <u>acute pulmonary edema</u> (c) <u>acute pulmonary edema</u>						INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u> <u>YRS.</u> <u>DAYS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>OLDX LUTIC AORTIC INSUFFICIENCY</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>JAN. 2, 1966</u> to <u>JAN 9, 1966</u> , that (I) (we) last saw the deceased alive on <u>JAN 9 1966</u> , and that death occurred at <u>4 PM</u> , from the causes and on the date stated above.		22a. SIGNATURE <u>Albert H. Grollman</u> M.D.	
22c. PHYSICIAN'S NAME (Type) <u>ALBERT H. GROLLMAN</u>		22d. ADDRESS <u>1106 SPRING ST. SPRING</u>		22b. DATE SIGNED <u>1/10/66</u>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 14, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Colmar Manor Md.</u>	
24. FUNERAL DIRECTOR <u>Arthur Walters</u>		25a. REC'D BY REGISTRAR <u>254 Carroll St. N.W. Washington, D.C. 20012</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. DATE <u>JAN 13 1966</u>	

MEDICAL CERTIFICATION

15280

88806

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&21 Film G373 2/23/66 TT

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00890

00872

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakoma Park</u>				c. LENGTH OF STAY IN 1p <u>15-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San + Hospital</u>				d. STREET ADDRESS <u>802 Philadelphia Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>Kate</u> Last <u>Collins</u>				4. DATE OF DEATH Month <u>1</u> Day <u>27</u> Year <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-29-1895</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>TENN.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>							
13. FATHER'S NAME <u>DANIEL M. WITT</u>				14. MOTHER'S MAIDEN NAME <u>ALICE J. McBEE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>EVELYN KELLY</u> Address <u>802 PHILADELPHIA AVE, SILVER SPRING MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac tamponade due to ruptured</u> <u>451X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ascending aortic aneurysm.</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Peap</u> M.O.				22. DATE SIGNED <u>JAN. 27, 1966</u>			
EXAMINER'S NAME (Type) <u>BELDEN R. PEAP M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>WASH. D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/28/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PROSPECT</u>		23d. LOCATION (City, town or county) (State) <u>WHITE PINE TENN</u>	
24. FUNERAL DIRECTOR <u>W. W. HARRIS CO. INC.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				DATE <u>FEB 4 1966</u>			

02690

FOR STATE
HEALTH DEPT.

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Item 21 Film G372 1/21/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00891

00873

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (rural) c. LENGTH OF STAY IN 1b 8 Months d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. Naval Hospital, NMMC, Bks. 12				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Illinois b. COUNTY Herrin c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 51-3 d. STREET ADDRESS Rt. 1, Box 297 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Richard Middle Louis Last Coloni				4. DATE OF DEATH Month January Day 12 Year 19 66			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 14, 1933	
9. AGE (In years last birthday) 32 yrs.		IF UNDER 1 YEAR Months 32 Days 3 Hours 12 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Herrin, Illinois				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Coloni				14. MOTHER'S MAIDEN NAME Juanita P. Whittaker			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 3/29-56 to 353 26 5803		17. INFORMANT Naval Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to aspiration of gastric contents DUE TO (b) Intoxication with alcohol and barbituates DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) He took overdose of drugs.			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 1210 p.m. Jan. 12 19 66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Barracks USNH		20f. (City or town) (County) (State) Bethesda Montgomery Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> pending							
ACTUAL SIGNATURE John G. Ball				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) John G. Ball, M. D.				22. DATE SIGNED 1/12/66			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/14/66		23c. NAME OF CEMETERY OR CREMATORY HERRIN, ILLINOIS		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR W.W. Chambers 1400 Chapin St., N.W. Washington D. C.				25a. REC'D BY REGISTRAR JAN 17 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

00881

Montgomery

Reynolds (Frank)

U.S. Naval Hospital, 1903, Bk. 10

Bl. 1, 1st 2nd

Richard

Clara

X

Dec. 10, 1903

Continued

U.S. Navy

History, Bk. 10

John Colton

Thomas E. Williams

U.S. Naval Hospital

Information was to be furnished to the
information with a label and photograph

in each average of drugs.

History, Jan. 10 - 1903

U.S. Naval Hospital

John E. Bell, M. D.

U.S. Naval Hospital, Bk. 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

BP

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
00892					00874				
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b, write RURAL and give nearest town <u>1 day 4 hours 20 min</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burtensville</u> d. STREET ADDRESS <u>3504 Spencerville Road.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>V. NMMI</u> Last <u>Colross</u>			4. DATE OF DEATH Month <u>January</u> Day <u>4</u> Year <u>1966</u>						
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 10, 1895</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u>1</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>			
13. FATHER'S NAME <u>Louis Valentine</u>			14. MOTHER'S MAIDEN NAME <u>Irma Linda Erma Linda</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>226-42-7359</u>		17. INFORMANT <u>Higgins Funeral Service Mt. Carmel Hospital/Records Pennsylvania</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Massive Cerebral Hemorrhage</u> DUE TO (c) <u>Hypertensive Cardiovascular Disease</u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1963</u> , 19 <u>66</u> , to <u>1/4</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1/3/66</u> 19 <u>66</u> , and that death occurred at <u>2:30</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Joseph E. Smith, Jr.</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-4-1966</u>		
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Smith, Jr.</u>					22d. ADDRESS <u>Burtensville, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Rural</u>		23b. DATE THEREOF <u>1-7-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Peters Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Northumberland County, Penna.</u>			
24. FUNERAL DIRECTOR <u>E. Glen Carter</u> ADDRESS <u>434 Georgia Avenue</u> <u>Warner E. Humphrey, Inc. Silver Spring, Md.</u>					25a. REC'D BY REGISTRAR <u>Jan 6 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		

100234

00883

CONFIDENTIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
00893													
00875													
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>20 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium & Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 15-1</u> d. STREET ADDRESS <u>212 Brewster Avenue</u> e. IS RESIDENCE DN A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Georgia Deulin Cox</u>			4. DATE OF DEATH <u>1</u> <u>22</u> <u>1966</u>			5. SEX <u>F</u>			6. COLOR OR RACE <u>Cauc.</u>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>1-31-87</u>			9. AGE (In years last birthday) <u>88</u>			IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>				11. BIRTHPLACE (County & State, or foreign country) <u>France</u>					
13. FATHER'S NAME <u>Frank Deulin</u>						14. MOTHER'S MAIDEN NAME <u>Unknown</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>234-03-2747</u>							
17. INFORMANT <u>Mrs. Florence Seibert</u> Address <u>212 Brewster Avenue Silver Spring, Md.</u>													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxemia from suppurating decubitus ulcers</u> 4200 DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Arteriosclerotic Heart Disease</u> (c) <u>Unknown</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												INTERVAL BETWEEN ONSET AND DEATH <u>30 days</u> <u>Known 30 days</u> <u>Unknown</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)													
21. I certify that (this hospital) attended the deceased from <u>Jan 2</u> , 1966, to <u>Jan 22</u> , 1966, that (I) (we) last saw the deceased alive on <u>Jan 21</u> , 1966, and that death occurred at <u>2 P. M.</u> from the causes and on the date stated above.													
22a. SIGNATURE <u>Aaron H. Traum</u>						22b. DATE SIGNED <u>January 24, 1966</u>							
22c. PHYSICIAN'S NAME (Type) <u>AARON H. TRAUM</u>						22d. ADDRESS <u>8237 Georgia Ave - Silver Spring Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>1/26/1966</u>				23c. NAME OF CEMETERY OR CREMATORY <u>East Oak Grove Cemetery</u>					
23d. LOCATION (City, town or county) <u>Morgantown, W. Virginia</u>				23e. (State) <u>West Virginia</u>									
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u>							
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>						DATE <u>JAN 26 1966</u>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00894		00876	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON 15-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>4200 GLENRIDGE ST</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY FRANCES BURTON COYNER</u>		4. DATE OF DEATH Month Day Year <u>JAN. 20 19 66</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> WIDOWED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-13-24</u>
9. AGE (In years last birthday) <u>41</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>5 7</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Union Bridge, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph BURTON</u>		14. MOTHER'S MAIDEN NAME <u>Louise Young</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-30-9244</u>	
17. INFORMANT <u>Husband</u> Address <u>Same as Item 2.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 5810 DUE TO (b) <u>Heart failure</u> DUE TO (c) <u>Coronary artery disease</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1966</u> , to <u>Jan 15, 1966</u> , that (I) (we) last saw the deceased alive on <u>19 Jan 1966</u> and that death occurred at <u>12:30</u> M. from causes and on the date stated above.			
22a. SIGNATURE <u>HORACE W. BERNTON</u>		22b. DATE SIGNED <u>1/20/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>HORACE W. BERNTON</u>		22d. ADDRESS <u>4743 Bradley Blvd, Chevy Chase, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-24-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY</u>		25a. REC'D BY REGISTRAR <u>JAN 24 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>James J. Judge</u>			

CERTIFICATE OF DEATH

00030

00030

[Faint, illegible text and markings on the certificate form, including fields for name, date, and cause of death.]



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

00895

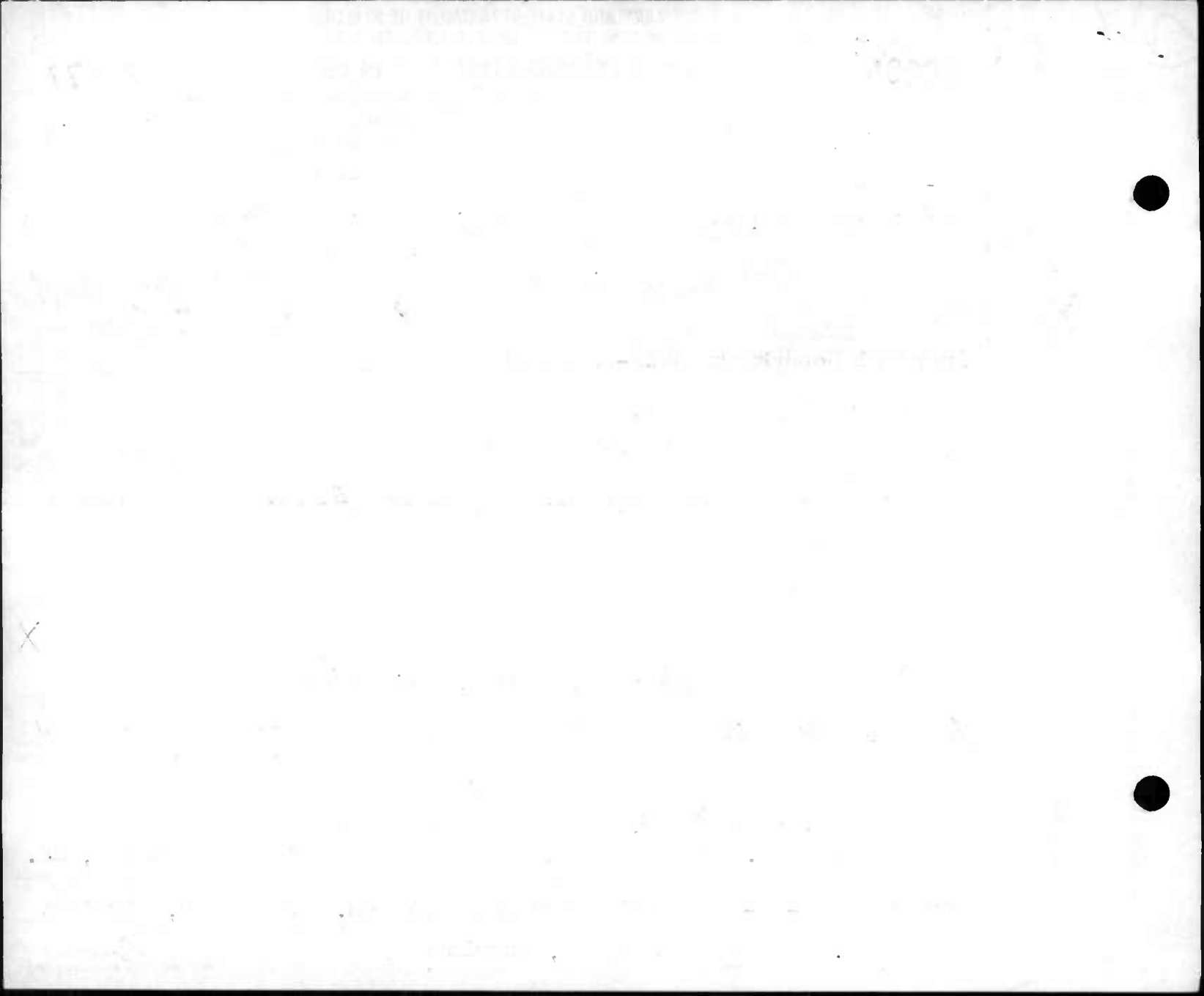
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00877

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8515 Rosewood Drive</u>			d. STREET ADDRESS <u>8515 Rosewood Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>John Lamb Crawford</u>			4. DATE OF DEATH <u>Jan. 20</u> 19 <u>66</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>April 19, 1914</u> 51 yrs.		9. AGE (In years lost birthday) <u>51</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Financial Consultant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Terre Haute, Ind.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Charles A. Crawford</u>			14. MOTHER'S MAIDEN NAME <u>Mary Simpson</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes WWII</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Patricia Crawford</u> Address <u>Bethesda, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun Shot Wounds of chest + Head -</u> 976 X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot Self with .25 cal. Pistol -</u>			
20c. TIME OF INJURY Month, Day, Year <u>5:50</u> Hour <u>a.m.</u> <u>1-20</u> 19 <u>66</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Bethesda Mont. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>1/20/66</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1-24-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY</u>		ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>JAN 24 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form MM-3. Page 5 may be retained for your files.

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00896

00878

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Gaithersburg, c. LENGTH OF STAY IN ID 2 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Alabama b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Evergreen d. STREET ADDRESS 318 Main Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBERT First F. Middle CROOM Last		4. DATE OF DEATH Month Jan. Day 21, Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/7/1888
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Government		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	
11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ? Croom		14. MOTHER'S MAIDEN NAME ? Cunningham	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 419-44-3037	
17. INFORMANT Mrs Betty C. Norman		Address 110 George Street Gaithersburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Insufficiency Acute - DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Cardio-Vascular Disease - DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emphysema -		INTERVAL BETWEEN ONSET AND DEATH Sudden - Years.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John G. Ball EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED 1/21/66			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit		23b. DATE THEREOF 1/24/66	
23c. NAME OF CEMETERY OR CREMATORY Evergreen		23d. LOCATION (City, town or county) (State) Evergreen, Alabama	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		25a. REC'D BY REGISTRAR 1331 Rockville Pike Rockville, Md.	
25b. REGISTRAR'S SIGNATURE John Charles Judge		DATE JAN 26 1966	

RECEIVED STATE DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
NATIONAL BUREAU OF HEALTH
WASHINGTON, D. C.

10000

TO THE SECRETARY OF THE DEPARTMENT OF HEALTH
FROM THE DIRECTOR OF THE DIVISION OF PUBLIC HEALTH
SUBJECT: [Illegible]

[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report containing several paragraphs of text, possibly including dates, names, and descriptive information. The text is organized into a formal document structure with a header, a body, and a footer area.]

Very respectfully,
[Illegible Signature]

[Illegible Title]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00897						00879					
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (rural) 98 days c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington 47-3 d. STREET ADDRESS 2916 2nd Street, S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Christina Ruth Crowder			4. DATE OF DEATH Month January 12 1966			5. SEX Female			6. COLOR OR RACE Caucasian		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH Feb. 1, 1931			9. AGE (In years last birthday) 34 yrs.			10. IF UNDER 1 YEAR Months 10 Days 11 Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Lewistown, Pennsylvania			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Walter Stevens				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes give war or dates of service) 177 24 8080				17. INFORMANT Mr. John P. Crowder, Washington, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 5270 IMMEDIATE CAUSE (a) Acute congestive atelectasis, pulmonary DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that (this hospital) attended the deceased from Oct. 6, 1965, to Jan. 12, 1966, that (we) last saw the deceased alive on Jan. 12, 1966, and that death occurred at 8:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE L. Brettschneider				22b. DATE SIGNED Jan. 12, 1966				22c. PHYSICIAN'S NAME (Type) L. Brettschneider			
22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.				23a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
23b. DATE THEREOF Jan. 14, 1966				23c. NAME OF CEMETERY OR CREMATORY Lind Memorial Cem.				23d. LOCATION (City, town or county) (State) Lewistown, Pennsylvania			
24. FUNERAL DIRECTOR R.A. Pumphrey, Bethesda, Maryland				25a. REC'D BY REGISTRAR JAN 17 1966				25b. REGISTRAR'S SIGNATURE J. C. ...			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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00898

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00880

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>N.Y. City</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>7 Akoma Park, Md.</u>		c. LENGTH OF STAY IN 1b <u>10 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. San. & Hospital, Tak Park, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Marie</u> Middle <u>Maxwell</u> Last <u>Cullen</u>		4. DATE OF DEATH Month <u>1</u> - Day <u>14</u> - Year <u>1966</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-24-79</u>
9. AGE (In years last birthday) <u>86 yrs.</u>		10. FINDER 1 YEAR Months <u>86</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles H. Raymond</u>		14. MOTHER'S MAIDEN NAME <u>Victoria Wooster</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>Dr Markwood, M.D.</u>		Address <u>3208-17th NW Wash D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arterio-sclerotic heart disease</u> <u>4200</u> DUE TO (b) <u>chronic myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>gastro-intestinal hemorrhage</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>gastro-intestinal bleeding</u>			INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>years</u> <u>3 weeks</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>56</u> , to <u>1-14</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1-14</u> 19 <u>66</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Dr H Markwood</u>		22b. DATE SIGNED <u>1-14-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>E H Markwood M.D.</u>		22d. ADDRESS <u>3208-17th NW</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>JAN 16, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GREENWOOD Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>BROOKLYN, N.Y.</u>
24. FUNERAL DIRECTOR <u>Jos. Gaudier's Sons</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>WASH. D.C.</u>		DATE <u>JAN 19 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00899

00881

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>41 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>				d. STREET ADDRESS <u>17408 Carroll Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harvey</u> Middle <u>Clement</u> Last <u>Dant</u>				4. DATE OF DEATH Month <u>January</u> Day <u>1</u> Year <u>1966</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 11, 1887</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months <u>78</u> Days <u>1</u> Hours <u>1</u> Min.	IF UNDER 24 HRS. Months <u>78</u> Days <u>1</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Plumbing Inspector - D.C.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>		11. BIRTHPLACE (County & State, or foreign country) <u>United States</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>
13. FATHER'S NAME <u>Thomas Clement DANT</u>				14. MOTHER'S MAIDEN NAME <u>IDA WARD</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-34-8817</u>		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1532</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adenocarcinoma, left colon</u> (c) <u>Adenocarcinoma, left colon</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 20, 1965</u> to <u>Jan 1, 1966</u> , that (II) (we) last saw the deceased alive on <u>Dec 31, 1965</u> , and that death occurred at <u>2</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>W. W. Eastman</u>				22b. DATE SIGNED <u>Jan 1, 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>W. W. EASTMAN</u>	
22d. ADDRESS <u>1200 Prospect St. Takoma Park, Md</u>				22e. ADDRESS <u>1200 Prospect St. Takoma Park, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 4, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR <u>Arthur Walters</u>		25a. REC'D BY REGISTRAR <u>Jan 4 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

0242

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
00900													
00882													
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 2 minutes d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 326 63rd St. N. E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Baby			First Girl			Middle DAY			Last				
5. SEX Female			6. COLOR OR RACE Negro			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH Jan. 2, 1966				
9. AGE (In years last birthday) 2			10. UNDER 1 YEAR 2			11. UNDER 24 HRS. 2			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Maryland				
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME Adele D. Day							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO.			17. INFORMANT Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity, immaturity at estimated 24 weeks gestation. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 776 X (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)				
21. I certify that the (this hospital) attended the deceased from Jan. 2, 1966 , to Jan. 2, 1966 , that the (we) last saw the deceased alive on Jan. 2, 1966 , and that death occurred at 702 PM from the causes and on the date stated above.													
22a. SIGNATURE Donald W. Cowherd						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED Jan. 4, 1966				
22c. PHYSICIAN'S NAME (Type) Donald W. Cowherd						22d. ADDRESS U. S. Naval Hospital Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 1-7-1966			23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Suitland - Md			23d. LOCATION (City, town or county) (State)				
24. FUNERAL DIRECTOR William Spangler ADDRESS Spangler Funeral Home 524 8 Street, N. E. Washington, D. C.						25a. REC'D BY REGISTRAR JAN 10 1966			25b. REGISTRAR'S SIGNATURE J. Charles Judge				

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

Items 18&21 Film G373 2/18/66 TM

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00883

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN 1b <u>16 1/2 hr.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. Jan. & Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> d. STREET ADDRESS <u>7006 ASPEN AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MABEL</u> Middle <u>Estelle</u> Last <u>DEHAVEN</u>		4. DATE OF DEATH Month <u>1</u> Day <u>20</u> Year <u>1966</u>	
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>5-1-91</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>MARTIN Pitzer</u>	
14. MOTHER'S MAIDEN NAME <u>MARTHA GLADEN</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Hosp. Records</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Tamponade due to hemopericardium</u> DUE TO (b) <u>secondary to rupture; left ventricle, due</u> DUE TO (c) <u>to acute myocardial infarction.</u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <u>4201</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u>		22. DATE SIGNED <u>JAN. 20, 1966</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		DEPUTY MEDICAL EXAMINER <u> </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 22, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Arthur Waller</u>		25a. REC'D BY REGISTRAR <u> </u>	
ADDRESS <u>254 Carroll AVE NW</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Judge</u>	
DATE <u>JAN 24 1966</u>			

0200

10

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

00902

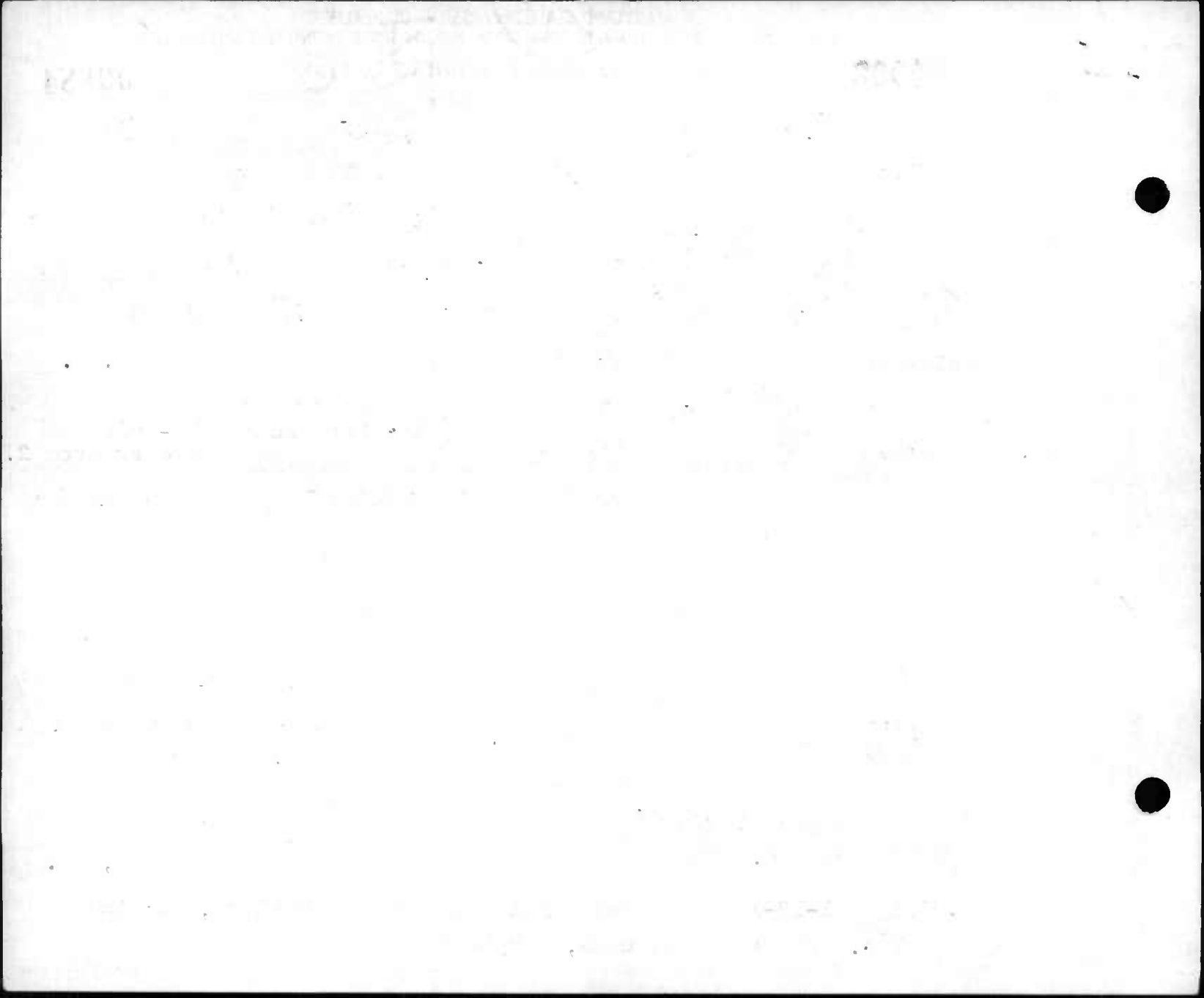
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00884

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germanatown</u> 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>		d. STREET ADDRESS <u>R.R. #2 - Box 129C1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert Beah Demshock</u> First Middle Last		4. DATE OF DEATH Month <u>1</u> Day <u>9</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-9-27</u> 38 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Printing</u>	11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>
13. FATHER'S NAME <u>John Joseph Demshock</u>		14. MOTHER'S MAIDEN NAME <u>Elm Katherine ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>Discharged 1946</u>		16. SOCIAL SECURITY NO. <u>577-405334</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun Shot Wound of Chest</u> 9198 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shooting Traps - Slipped in mud & gun discharged accidentally</u>	
20c. TIME OF INJURY Month, Day, Year <u>12-05 p.m. 1/9/66</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Woods</u>	20f. (City or town) <u>Germanatown</u> (County) <u>Mont.</u> (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED <u>1/10/66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-12-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY</u>		23d. LOCATION (City or Town) <u>Suitland, Maryland</u> (County) _____ (State) _____	25a. REC'D BY REGISTRAR <u>JAN 13 1966</u>
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00903

00885

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 5 1/2 hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Eddie		4. DATE OF DEATH 1-24-66	
5. SEX Female		6. COLOR OR RACE Negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 3, 1897	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Wash., D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Redmond		14. MOTHER'S MAIDEN NAME Ruize Matthews	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Admission Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute, severe, lobar 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) pneumonia, right lower DUE TO (c) lobe.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap		22. DATE SIGNED 1-24-66	
EXAMINER'S NAME (Type) Belden R. Reap, M. D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Wheaton, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1/28/66	
23c. NAME OF CEMETERY OR CREMATORY Ash Memorial		23d. LOCATION (City, town or county) (State) Sandy Spring, Md.	
24. FUNERAL DIRECTOR Robert L. Swarden		25a. REC'D BY REGISTRAR B 1	
ADDRESS Rockville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

00904

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00886

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Forestville	
c. LENGTH OF STAY IN 1b 28 Days		d. STREET ADDRESS 16-2	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Vito (NMN) Di Trapani		4. DATE OF DEATH January 25 19 66	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11 January 1913	
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Milkman		10b. KIND OF BUSINESS OR INDUSTRY Dairy	
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Marco Di Trapani		14. MOTHER'S MAIDEN NAME Agatha Launi	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Not Available	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal hemorrhage, Peptic ulcer DUE TO (b) Hodgkin's Disease DUE TO (c) 201X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 1 day 3 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that NO (this hospital) attended the deceased from 28 December 19 65 to 25 January 19 66 , that W (we) last saw the deceased alive on 25 January 19 66 , and that death occurred at 10:00 A. from the causes and on the date stated above.			
22a. SIGNATURE Wesley M. Vietzke		22b. DATE SIGNED 25 January 1966	
22c. PHYSICIAN'S NAME (Type) Wesley M. Vietzke, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1/28/66	
23c. NAME OF CEMETERY OR CREMATORY NATIONAL MEM PARK		23d. LOCATION (City, town or county) (State) W/2	
24. FUNERAL DIRECTOR W.W. Chambers		25a. REC'D BY REGISTRAR SE DC	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE FEB 1 1966	

110888

00004

Health Center

Portland

Portland

Portland

28 Feb

Portland

1000 West Bond Street, Apt. 302

The Clinical Center, Portland, ME

68

January 25

11 February

(1968)

Via

11 January 1968

John

John

USA

Washington, D.C.

John

John

Agnes Scott

John D. Wright

The Medical Record

Not available The Clinical Center, Portland, ME, Portland

68

1 day

Administrative Services, Portland, ME

3 years

Robert's Disease

25 January 1968

The Clinical Center, National
Institute of Health, Bethesda, MD

Dr. M. Victor, M.D.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00905

CERTIFICATE OF DEATH

00887

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING Md.</u>				c. LENGTH OF STAY IN 1b <u>20 hr.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>				e. STREET ADDRESS <u>8537 GLENN DALE RD.</u>			
3. NAME OF DECEASED (Type or print) <u>Christopher E Doolittle</u>				4. DATE OF DEATH <u>1 15 19 66</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/11/45</u>	
9. AGE (In years last birthday) <u>3</u> yrs.		10. MONTHS <u>4</u>		11. IF UNDER 1 YEAR <u>15</u> Days		12. IF UNDER 24 HRS. <u>19</u> Hours <u>66</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>MONTGOMERY - Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>US</u>			
13. FATHER'S NAME <u>Robert E. Doolittle</u>				14. MOTHER'S MAIDEN NAME <u>ELaine Haddock</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>ROBERT E DOOLITTLE GREEN BELT MD</u>				Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>meningitis</u> <u>3401</u> DUE TO (b) <u>Septicemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Pneumococcus</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY <u>19</u> Month, Day, Year		20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/14</u> , 19 <u>66</u> to <u>1/15</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>1150</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Martin Mones</u>				22b. DATE SIGNED <u>1/15/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>MARTIN MONES</u>				22d. ADDRESS <u>2503 1110 Springs St Silver Spring Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 17, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Colmar Manor, Maryland.</u>	
24. FUNERAL DIRECTOR <u>F. Gaschissens</u>				25a. REC'D BY REGISTRAR <u>1/19 1966</u>			
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

5-177742

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00906

00888

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>2mo - 18 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>FAIRLAND Nursing Home 210 FAIRLAND RD</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. George</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> d. STREET ADDRESS <u>315 Talbott Avenue</u>							
3. NAME OF DECEASED (Type or print) First <u>Abby</u> Middle <u>DORSEY</u> Last <u>DORSEY</u>			4. DATE OF DEATH Month <u>JAN</u> Day <u>6</u> Year <u>1966</u>								
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>							
8. DATE OF BIRTH <u>Jan 27 1898</u>		9. AGE (In years last birthday) <u>77 25</u> yrs. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		Hours		Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.										
Months	Days										
	Hours										
	Min.										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>							
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>											
13. FATHER'S NAME <u>William H. Brown</u>			14. MOTHER'S MAIDEN NAME <u>Sara Louise Rawler</u>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>26-46-2010</u>		17. INFORMANT <u>Mary A. Barton</u> Address <u>Laurel, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Attack</u> (b) <u>451X</u> DUE TO <u>Septic Intra-aortic Aortic Aneurysm</u> (c) <u>underlying cause last</u> DUE TO <u>General Atherosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> <u>19</u> to <u>Jan 6</u> , <u>1966</u> , that (I) (we) last saw the deceased alive on <u>Jan 6</u> , <u>1966</u> , and that death occurred at <u>1:55 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Robert C. Wingfield</u>			22b. DATE SIGNED <u>Jan 6 1966</u>								
22c. PHYSICIAN'S NAME (Type) <u>ROBERT C. WINGFIELD</u>			22d. ADDRESS <u>Laurel Md.</u>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-8-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dorsey Family Cem</u>							
23d. LOCATION (City, town or county) (State) <u>Annapolis Junction Md</u>											
24. FUNERAL DIRECTOR <u>De Witt Donaldson</u>			25a. REC'D BY REGISTRAR <u>JAN 11 1966</u>								
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00884

CENTINATE OF 1841

00884

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "first" and "second" are faintly visible.]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

00907

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02442

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Etchison</u>		c. LENGTH OF STAY IN 1b <u>4 years</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Etchison</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.F.D. 2 Gaithersburg</u>		d. STREET ADDRESS <u>R.F.D. Gaithersburg</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>James Doye</u>		4. DATE OF DEATH <u>Jan 30 1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 11, 1880</u> 85 yrs.
9. AGE (In years last birthday) <u>85</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nathan Doye</u>		14. MOTHER'S MAIDEN NAME <u>Mary Wilson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypothermia</u> 9320 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Exposure to snow + cold weather</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Walked out in snow became fatigued</u>	
20c. TIME OF INJURY Month, Day, Year <u>8 p.m. 1/30 1966</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Etchison. Montgomery Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22. DATE SIGNED <u>2/3/66</u>	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>2/10/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Brooke Grove</u>	23d. LOCATION (City or Town) (County) (State) <u>Laytonsville Montg. Md.</u>
24. FUNERAL DIRECTOR <u>Robert L. Snowden Rockville, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 14 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

SP250

0000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00908

CERTIFICATE OF DEATH

00889

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Olney</u> c. LENGTH OF STAY IN lb <u>46 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Brooke Grove Foundation</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>"</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>"</u> d. STREET ADDRESS <u>512 Oneida Place, N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Sara</u> Middle <u>Mabel</u> Last <u>Drissel</u>				4. DATE OF DEATH Month <u>January</u> Day <u>22</u> Year <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 16-1895</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pennsylvania</u>		11. BIRTHPLACE (County & State, or foreign country) <u>U.S.</u>	
13. FATHER'S NAME <u>Jessie K. Horne</u>				14. MOTHER'S MAIDEN NAME <u>Kaufman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-62-6552</u>		17. INFORMANT <u>Winfield L. Drissel - 404 Woodland Rd. - Gaithersburg Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY CONGESTION</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>CEREBRAL VASCULAR ACCIDENT</u> DUE TO (a), stating the underlying cause last. (c) <u>ARTERIOSCLEROSIS - GENERAL</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>1 WK</u> <u>YRS.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>ORGANIC BRAIN SYNDROME</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/28</u> , 19 <u>65</u> to <u>1/22</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1/21</u> , 19 <u>66</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Donald R. Lewis</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/22/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>DONALD R. LEWIS MD</u>				22d. ADDRESS <u>700 CLOVERLY SILVER SPRING Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/26/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince Geo. Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lyson Wheeler Funeral Home</u>				25a. REC'D BY REGISTRAR <u>JAN 26 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

00909

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00890

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>NEW JERSEY</u> b. COUNTY <u>ESSEX</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEWARK</u> <u>67-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>75 Hobson St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>O'Neal DAVID Drummond</u>				4. DATE OF DEATH Month Day Year <u>JAN 29 19 66</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>JAN 6, 1925</u>	9. AGE (In years last birthday) <u>41</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NEW CAR PAINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FRANCIS CHEVROLET</u>		11. BIRTHPLACE (State or foreign country) <u>Greenville South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Drummond</u>				14. MOTHER'S MAIDEN NAME <u>SALLY DURHAM</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES NAVY</u>		16. SOCIAL SECURITY NO. <u>251-22-6645</u>	17. INFORMANT <u>NEPHEW</u> <u>SHERMAN DRUMMOND</u>		Address <u>121 PENN. AVE NEWARK N.J.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Injuries Severe</u> 8194 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Trauma from auto accident -</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Drove his car in to bridge abutment</u>					
20c. TIME OF INJURY Month, Day, Year <u>4 45 a.m. 1/29 1966</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Bethesda Montgomery Md.</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John S. Ball</u>		EXAMINER'S NAME (Type) _____		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <u>1/29/66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) _____		23b. DATE THEREOF <u>2-1-66</u>	23c. NAME OF CEMETERY OR CREMATORY _____		23d. LOCATION (City or Town) (County) (State) <u>Newark N.J.</u>		
24. FUNERAL DIRECTOR <u>R.N. Horton Co.</u>		ADDRESS <u>1324 4th St. NW.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE _____	

00100

THE NEW YORK PUBLIC LIBRARY

00200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00910 CERTIFICATE OF DEATH 00891											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> c. LENGTH OF STAY IN 1b <u>2 months</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home</u>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u> d. STREET ADDRESS <u>83-3</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Anna Latruite Duffey</u> First Middle Last						4. DATE OF DEATH <u>Jan 6 1966</u> Month Day Year <u>6:40 P.M.</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>Caus.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/27/1813</u>		9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Music Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Middleburg, Virginia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>		
13. FATHER'S NAME <u>Samuel E. Duffey</u>						14. MOTHER'S MAIDEN NAME <u>Amanda Smith</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>218-40-4015</u>		17. INFORMANT <u>Mrs. C. Duffey Collins</u> Address <u>1732 N Veitch Arlington Va</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary atherosclerotic Heart Disease</u> <u>4200</u> DUE TO <u>Generalized atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized atherosclerosis</u> DUE TO (c) <u>Generalized atherosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>years</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>11 -</u> , 19 <u>65</u> , to <u>1-21-</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1-20</u> , 19 <u>66</u> , and that death occurred at <u>6:40 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Irwin H. Ardham</u>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <u>1-21-66</u>		
22c. PHYSICIAN'S NAME (Type) <u>IRWIN H. ARDHAM, M.D.</u>						22d. ADDRESS <u>1712 - I - ST, N.W., WASH 6, D.C.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-21-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sharon</u>				23d. LOCATION (City, town, or county) (State) <u>Middleburg, Va.</u>			
24. FUNERAL DIRECTOR <u>Robert J. Mulcahy</u>						25a. REC'D BY REGISTRAR <u>Jan 24 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

JAN 24 1966

00800

00800

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "THE" and "OF" are visible.]

2

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DR. REAR NOTIFIED AND APPROVES RELEASE

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00911					00892				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <u>MONTGOMERY</u> MARYLAND					a. STATE <u>MASS.</u> b. COUNTY				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WORCESTER</u> 58-3				
c. LENGTH OF STAY IN Id <u>12 mos.</u>					d. STREET ADDRESS <u>37 KENWOOD AVE</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CHEVYCHASE NURSING-CONVALESCENT CENTER</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>PHILIP Henry DUPREY</u>					4. DATE OF DEATH <u>JAN. 21 1966</u>				
First Middle Last					Month Day Year				
5. SEX <u>MALE</u>					6. COLOR OR RACE <u>WHITE</u>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>9/29/78</u>				
9. AGE (In years last birthday) <u>87</u> yrs.					10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REAL ESTATE</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>				
11. BIRTHPLACE (County & State, or foreign country) <u>West Boylston, Mass.</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Unknown Duprey</u>					14. MOTHER'S MAIDEN NAME <u>Unknown Du Bois</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>None</u>				
17. INFORMANT <u>Mrs. Mary D. Hoehling</u>					Address <u>3423 Oliver St., N.W. Washington, D.C.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> <u>4200</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DUE TO</u> (c) <u>DUE TO</u>					INTERVAL BETWEEN ONSET AND DEATH <u>YRS-</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CEREBRAL ARTERIOSCLEROSIS</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (II) (this hospital) attended the deceased from <u>MAY</u> , 19 <u>65</u> , to <u>JAN 21</u> , 19 <u>66</u> , that (II) (we) last saw the deceased alive on <u>JAN. 8</u> , 19 <u>66</u> , and that death occurred at <u>5:15 A.M.</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>H D Ecker</u>					22b. DATE SIGNED <u>1/21/66</u>				
22c. PHYSICIAN'S NAME (Type) <u>HENRY D. ECKER</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
22d. ADDRESS <u>917-20th ST. N.W. - WASHINGTON DC.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>1-24-66</u>				
23c. NAME OF CEMETERY OR CREMATORY <u>Notre Dame</u>					23d. LOCATION (City, town or county) (State) <u>Worcester, Mass.</u>				
24. FUNERAL DIRECTOR <u>John B. Thomas</u> ADDRESS <u>8434 Georgia Avenue</u>					25a. REC'D BY REGISTRAR <u>JAN 26 1966</u>				
<u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>					25b. REGISTRAR'S SIGNATURE <u>William J. Judge</u>				

00200

00200



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00912		Items #15 & 16 Film #G373 1/26/66 pc						00893			
1. PLACE OF DEATH Suburban Hosp a. COUNTY Bethesda. Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Montg,					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg.					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hosp,						d. STREET ADDRESS 205 Tulip Drive					
3. NAME OF DECEASED (Type or print) First Robert Middle LeRoy Last Dutrow						4. DATE OF DEATH Month Jan Day 13th Year 1966					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 21st 1914		9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Policeman		10b. KIND OF BUSINESS OR INDUSTRY III		11. BIRTHPLACE (County & State, or foreign country) Montg, Co, Md,				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Wm. Milton Dutrow						14. MOTHER'S MAIDEN NAME Manie Purdum					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes						16. SOCIAL SECURITY NO. 6/10/42-10/45		17. INFORMANT Gladys B. Dutrow. Gaithersburg. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Melastatic Cancer Liver 1538 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer Colon (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 2 mos 3 mos	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Dec 1965 to 13 Jan 1966, that (I) (we) last saw the deceased alive on 12 Jan 1966, and that death occurred at 4 M, from the causes and on the date stated above.											
22a. SIGNATURE WM S Murphy, Md.						22b. DATE SIGNED 17 1966		22c. PHYSICIAN'S NAME (Type) WM S Murphy, Md.		22d. ADDRESS 615 W. Montg. Ave. Rockville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-15-66		23c. NAME OF CEMETERY OR CREMATORY Clarksburg Cemetery		23d. LOCATION (City, town or county) (State) Clarksburg, Md.					
24. FUNERAL DIRECTOR'S SIGNATURE Charles E. Gaithersburg						25a. REC'D BY REGISTRAR DATE 17 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00913 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00894

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Ad.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Damascus</u>		c. LENGTH OF STAY IN 1b <u>D.O.D.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Clearwater Court</u>		d. STREET ADDRESS <u>Hawkins Creamery & Woodfield Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Celius</u> Middle <u>Vernon</u> Last <u>Duvall</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>22</u> Year <u>1966</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/11/86</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Celius Duvall</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Catherine King</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Herbert Duvall, Olney, Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency acute.</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cardiovascular disease.</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs.</u> <u>years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u> </u> <u> </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1/22/66</u>	
EXAMINER'S NAME (Type) <u>John G. Ball, M.D.</u>		22. DATE SIGNED <u>1/22/66</u> Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Jan. 25, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Damascus Meth.</u>	23d. LOCATION (City, town or county) (State) <u>Damascus, Md.</u>
24. FUNERAL DIRECTOR <u>Olin L. Molesworth, Damascus, Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 26 1966</u> DATE	
25b. REGISTRAR'S SIGNATURE <u>John G. Ball</u>		25c. REGISTRAR'S NAME <u>John G. Ball</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

VR A15 (4)
20M 1/65

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Home

H. Wife

220-31-1842

Bartonville, Mo.

Bartonville Union

1-23-00

Serial

Lyttonville, Mo.

Francis H. Barber

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00915 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. LENGTH OF STAY IN 1b <u>2 mo -</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8. Brooks Ave -</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Montgomery</u> <u>06-2</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>E</u> Last <u>Earnest</u>		d. STREET ADDRESS <u>12-3</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 7-1908</u> <u>62</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired) <u>disabled</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Silas Earnest</u>		14. MOTHER'S MAIDEN NAME <u>Anna Cusick</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Emma H. Earnest</u>		Address <u>Montgomery, md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John B. Bell</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-7-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Gaithersburg</u> <u>md</u>	
24. FUNERAL DIRECTOR <u>Emmet C. Garton</u>		ADDRESS <u>Gaithersburg</u>	
25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>20 1966</u>			

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FOR STATE
HEALTH DEPT.

00916

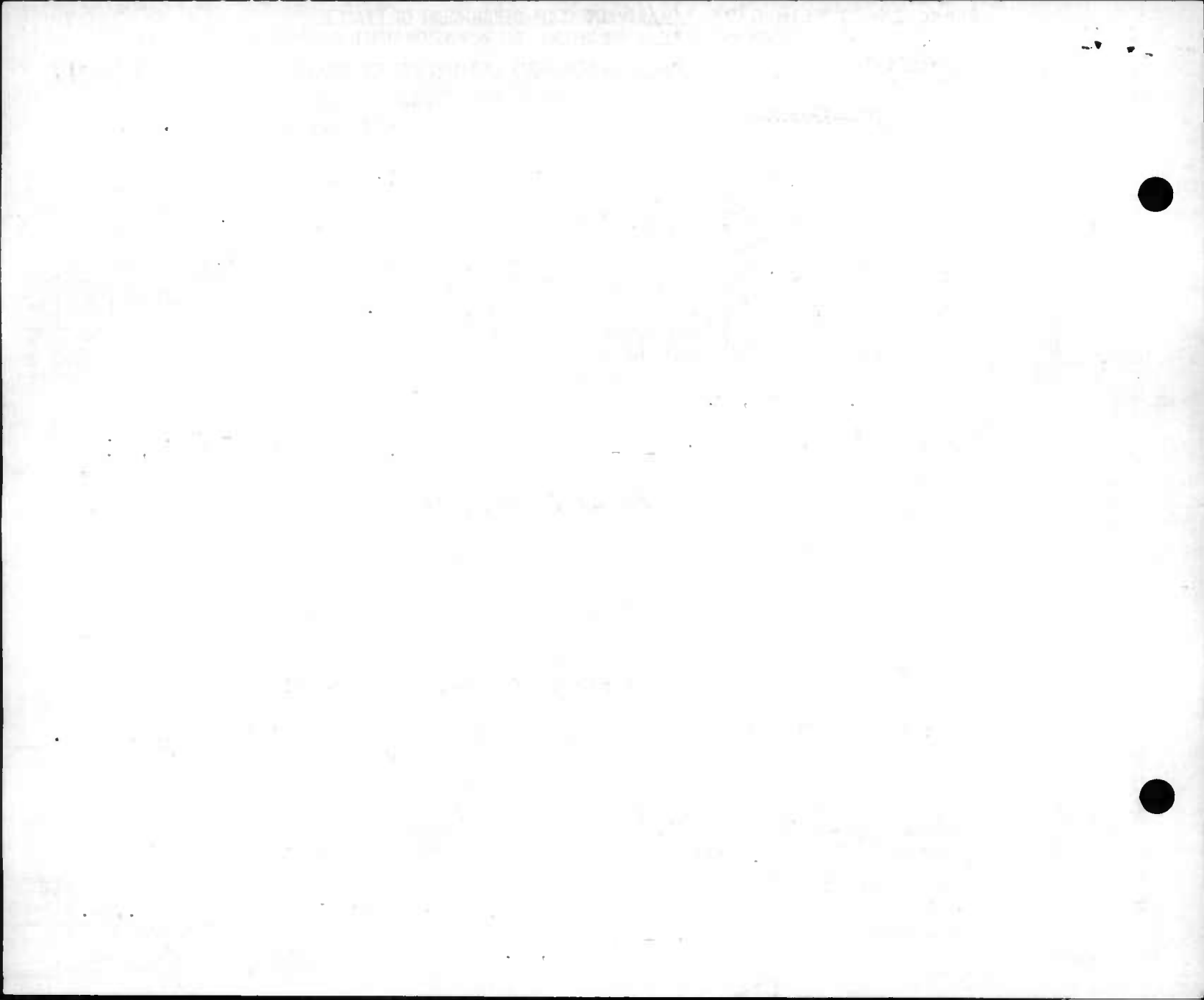
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00897

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in only event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		d. STREET ADDRESS <u>741 Monroe Street - Apt 201</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>741 Monroe Street - Apt 102</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Harlan James Eastman Jr</u>		4. DATE OF DEATH <u>Jan - 14 1966</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec - 24, 1918</u>
9. AGE (In years last birthday) <u>47 yrs.</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harlan J. Eastman, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Susan Culmer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>209-05-7247</u>	
17. INFORMANT <u>Henrietta L. Eastman</u>		Address <u>5731 29th Ave. Apt 3 Hyattsville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>9718 1/4 Addict Drug poisoning</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Took overdose of drugs and alcohol</u>	
20c. TIME OF INJURY Month, Day, Year <u>5:00 p.m. 1/14 1966</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Rockville Montg. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		22. DATE SIGNED <u>1/15/66</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/18/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Memorial</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince George Co., Md.</u>	
24. FUNERAL DIRECTOR <u>Lyson Wheeler Funeral Home - 1300 Rockville Pike Rockville, Md.</u>		25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>JAN 19 1966</u>	



CERTIFICATE OF DEATH

Reg. Dist. No.

00917

00898

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5402 Lambeth Road		d. STREET ADDRESS 5402 LAMBETH ROAD	
3. NAME OF DECEASED (Type or print) First Everett Clayton Middle Embrey, Sr. Last Embrey, Sr.		4. DATE OF DEATH Month January Day 7 Year 1966	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 16, 1903
9. AGE (In years lost birthday) yrs. 62		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer		10b. KIND OF BUSINESS OR INDUSTRY Engineering	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Warren Embrey		14. MOTHER'S MAIDEN NAME - - -	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-01-2429	
17. INFORMANT 9603 Parkwood Dr.		18. ADDRESS E. Clayton Embrey, Jr. - Bethesda, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO Cardiac Failure Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Generalized Carcinomatosis - Colon DUE TO Primary (c) Colon			
INTERVAL BETWEEN ONSET AND DEATH 6 hrs 3 days 3 month			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 45 , to January 7 1966 , that I last saw the deceased alive on January 7 1966 , and that death occurred at 8:30 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5707 Wisconsin Ave DATE SIGNED 1/7/66			
ACTUAL SIGNATURE Frank Y Jaggers Jr. M.D.		PHYSICIAN'S NAME (Type) Frank Y Jaggers Jr. M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/11/66	
22c. NAME OF CEMETERY OR CREMATORY National Memorial Park		22d. LOCATION (City, town, or county) (State) Falls Church, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Jos. Gawler's Sons, 5130 Wis. Ave, Wash, D.C.		24a. REC'D BY REGISTRAR JAN 13 1966	
24b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

0001

DECEASED

DATE OF DEATH

1-10-1918

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

OCCUPATION

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

OCCUPATION

EDUCATION

RELIGION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00918 00899											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>6 yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>15-1</u>				d. STREET ADDRESS <u>4706 Creek Shore Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4706 Creek Shore Drive</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)			First <u>Ralph</u> Middle <u>Edward</u> Last <u>England</u>			4. DATE OF DEATH Month <u>January</u> Day <u>8</u> Year <u>19 66</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 10, 1916</u>		9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
										IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Government</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Missouri</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Walter England</u>						14. MOTHER'S MAIDEN NAME <u>Sarah Salmon</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>Will</u> <u>500-09-6510</u>		17. INFORMANT <u>Mrs. Marguerite England</u>			Address <u>4706 Creek Shore Dr. Silver Spring, Md.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)											
<u>4201</u> DUE TO <u>Coronary Arteriosclerosis</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerosis</u>											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 3, 1966</u> to <u>Jan 8, 1966</u> that (I) (we) last saw the deceased alive on <u>Jan 8, 1966</u> and that death occurred at <u>10 PM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>John G. Curry, M.D.</u>											
22c. PHYSICIAN'S NAME (Type) <u>John G. Curry, M.D.</u>											
22d. ADDRESS <u>10620 Georgia Ave</u>											
22e. DATE SIGNED <u>1/8/66</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>1-12-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>						ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>			25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>		
						25b. REGISTRAR'S SIGNATURE					

00200

00818

ALL
GIVEN

1
- FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00919

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02447

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Damascus</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Near Long Corn. Rd.</u>		d. STREET ADDRESS <u>139 Middle Lane</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Noah</u> First <u>Ennis</u> Middle Last		4. DATE OF DEATH Month <u>Jan</u> Day <u>30</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 23 1916</u>
9. AGE (In years lost in thdy) yrs. <u>49</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Country Club</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Sam</u>		14. MOTHER'S MAIDEN NAME <u>Bertie Leadwin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-26-2463</u>	
17. INFORMANT <u> </u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>9328</u> IMMEDIATE CAUSE (a) <u>Hypothermia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Exposure to cold weather</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Walking in snow blizzard thinly clad -</u>	
20c. TIME OF INJURY Month, Day, Year <u>12</u> <u>am</u> <u>1 30</u> 19 <u>66</u>		20d. INJURY OCCURRED <input type="checkbox"/> While at work <input checked="" type="checkbox"/> Not While at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Field</u>		20f. (City or town) (County) (State) <u>R. Damascus Mont. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Bell</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>7936 Old Georgetown Road, Bethesda, Md.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>2/2/66</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <u> </u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/5/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Neelsville Church Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Neelsville, Maryland</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home - 1331 Rockville Pike</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
Address <u>Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>FEB 8 1966</u>			

1930

1930

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
00920									
1. PLACE OF DEATH a. COUNTY Montgomery, Kensington MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 10231 Carroll Pl. c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Carroll Hall Sanitarium					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D. C. b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 4424 Volta Pl. N. W. 47-3 d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle A Last ESAU			4. DATE OF DEATH Month JANUARY Day 1 Year 1966		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Aug. 8, 1876 9. AGE (In years last birthday) 89 yrs. IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Edward Shannon					14. MOTHER'S MAIDEN NAME Julie Harvey				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. -		17. INFORMANT John W. Esau Address 5 Crescent Road N.Y. Port. Washington, L.I.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 444X ARTERIOSCLEROTIC HEART DISEASE DUE TO (b) ESSENTIAL HYPERTENSION DUE TO (c) GENERALIZED ARTERIOSCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) SENILITY INTERVAL BETWEEN ONSET AND DEATH									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (I) (the hospital) attended the deceased from DEC. 24, 1965, to JAN. 1, 1966, that (I) (we) last saw the deceased alive on JAN. 1, 1966, and that death occurred at 9:50 M, from the causes and on the date stated above.									
22a. SIGNATURE Henry Louden					22b. DATE SIGNED 1/1/66			22c. PHYSICIAN'S NAME (Type) M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 5206 Normal St. Cherry Chase, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/5/66		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION (City, town or county) (State) Brooklyn, N. Y.			
24. FUNERAL DIRECTOR Robert A. DeVoe					25a. REC'D BY REGISTRAR DATE JAN 5 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

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STATE OF TEXAS

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[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "STATE OF TEXAS" and "COUNTY OF" are faintly visible.]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00921

00901

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>5603 Lone Oak Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>Thomas H. Evans</u>		4. DATE OF DEATH <u>Jan 26</u> 19 <u>66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 5, 1908</u>
9. AGE (If years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR <u>9</u> Months <u>11</u> Days <u>15</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Special Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Supply Club</u>	
11. BIRTHPLACE (State or foreign country) <u>Great Britain</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Evans</u>		14. MOTHER'S MAIDEN NAME <u>May Ann Lewis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Vivian Evans</u>		Address <u>Bethesda, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio Vascular Disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
22. DATE SIGNED <u>1/26/66</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial - transit</u>		23b. DATE THEREOF <u>1/29/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fern Knoll Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Dallas, Tex., Penna.</u>	
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
25a. REC'D BY REGISTRAR <u>FEB 4 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>									
1. PLACE OF DEATH a. COUNTY <div style="text-align: center;">MONTGOMERY</div>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <div style="text-align: center;">Maryland</div>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <div style="text-align: center;">Chevy Chase</div>					c. LENGTH OF STAY IN 1b <div style="text-align: center;">15-1</div>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <div style="text-align: center;">6302 Stratford Road</div>					d. STREET ADDRESS <div style="text-align: center;">6302 Stratford Road</div>				
3. NAME OF DECEASED <div style="text-align: center;"> First Middle Last IRA CLINTON EVERETT </div>					4. DATE OF DEATH <div style="text-align: center;"> Month Day Year January 30 1966 </div>				
5. SEX <div style="text-align: center;">Male</div>		6. COLOR OR RACE <div style="text-align: center;">White</div>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <div style="text-align: center;">WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div>		8. DATE OF BIRTH <div style="text-align: center;">2-27-1898</div>		9. AGE (In years last birthday) <div style="text-align: center;">67 yrs.</div>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="text-align: center;">Claim Manager (Retired)</div>		10b. KIND OF BUSINESS OR INDUSTRY <div style="text-align: center;">Aetna Cas. & Surety Co.</div>		11. BIRTHPLACE (County & State, or foreign country) <div style="text-align: center;">Pennsylvania</div>		12. CITIZEN OF WHAT COUNTRY? <div style="text-align: center;">U.S.A.</div>			
13. FATHER'S NAME <div style="text-align: center;">Alben Osborn Everett</div>					14. MOTHER'S MAIDEN NAME <div style="text-align: center;">Emma Catherine Hayman</div>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <div style="text-align: center;">No</div>					16. SOCIAL SECURITY NO. <div style="text-align: center;">577-03-7911</div>				
17. INFORMANT <div style="text-align: center;">Dorothea Everett, See Item No. 2</div>					Address 				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <div style="text-align: center;">MYOCARDIAL INFARCTION</div>									
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.									
DUE TO (b) <div style="text-align: center;">CORONARY OCCLUSION</div>									
DUE TO (c) <div style="text-align: center;">ARTERIOSCLEROSIS</div>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? <div style="text-align: center;">YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year <div style="text-align: center;">Hour a.m. p.m. 19</div>			20d. INJURY OCCURRED <div style="text-align: center;">While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></div>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from _____, 19 35, to Jan 30, 1966, that (I) (we) last saw the deceased alive on OCT 1966, and that death occurred at 12 PM, from the causes and on the date stated above.									
22a. SIGNATURE <div style="text-align: center;">W. Tabb Moore</div>					22b. DATE SIGNED <div style="text-align: center;">1/30/66</div>				
22c. PHYSICIAN'S NAME (Type) <div style="text-align: center;">W. TABB MOORE</div>					22d. ADDRESS <div style="text-align: center;">2001 I St. NW</div>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <div style="text-align: center;">Removal</div>		23b. DATE THEREOF <div style="text-align: center;">2-2-1966</div>		23c. NAME OF CEMETERY OR CREMATORY <div style="text-align: center;">Union Cemetery</div>		23d. LOCATION (City, town or county) (State) <div style="text-align: center;">Slatington, Pa.</div>			
24. FUNERAL DIRECTOR <div style="text-align: center;">Joseph Gawler's Sons, Inc.</div>									
25a. REC'D BY REGISTRAR <div style="text-align: center;">FEB 8 1966</div>									
25b. REGISTRAR'S SIGNATURE <div style="text-align: center;">Charles Judge</div>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00923		Items #7 & 12 Film #3373 2/1/66 DC		00902		Items #4 & 6 Film #3373 2/1/66 DC					
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>Blair House, 8201 16th St. S.S. Maryland</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u> c. LENGTH OF STAY IN b <u>15-1</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Silver Spring, Maryland</u> <u>Blair House</u> <u>8201 16th Street Apt. #506</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Silver Spring</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Maryland</u> d. STREET ADDRESS <u>Blair House</u> <u>8201 16th Street Apt. #506</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>HARRY</u> First Middle Last <u>FAIGEN</u>			4. DATE OF DEATH <u>Jan. 27</u> Month Day Year <u>1966</u>			5. SEX <u>Male</u>			6. COLOR OR RACE <u>White</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>Nov. 30, 1888</u>			9. AGE (In years last birthday) <u>77</u> yrs.			10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dry Cleaner</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Russia</u>			11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Geashon Faigen</u>						14. MOTHER'S MAIDEN NAME <u>3416 Mansfield Rd.</u> <u>Mr. Seymour Faigen Falls Church, Va.</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT <u>3416 Mansfield Rd.</u> <u>Mr. Seymour Faigen Falls Church, Va.</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>1538</u> DUE TO <u>Adenocarcinoma of colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c) 2 weeks 2 mos.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> , 19 <u>65</u> , to <u>Jan 27</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Jan 26</u> 19 <u>66</u> , and that death occurred at <u>3A</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Simon C. Weiner</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>Jan 27, 1966</u>		
22c. PHYSICIAN'S NAME (Type) <u>Dr. Simon C. Weiner, M.D.</u>						22d. ADDRESS <u>8201-16 St. Silver Spring, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>1/30/66</u>			23c. NAME OF CEMETERY OR CREMATORY <u>King David Memorial Gdn.</u>			23d. LOCATION (City, town or county) (State) <u>Falls Church, Va.</u>		
24. FUNERAL DIRECTOR <u>BERNARD DANZANSKY & SONS</u>						25a. REC'D BY REGISTRAR <u>3501 14th St.</u>			25b. REGISTRAR'S SIGNATURE <u>1/27/66</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park Md.		c. LENGTH OF STAY IN 1b 38 hrs 38 min		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY MONTGOMERY		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium & Hosp						d. STREET ADDRESS 8002 Eastern Drive			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) ISIDORE (KMN) FELDMAN						4. DATE OF DEATH Month 1 Day 8 Year 1966					
5. SEX MALE		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-22-96		9. AGE (In years, last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GROCCER				10b. KIND OF BUSINESS OR INDUSTRY GROCERY		11. BIRTHPLACE (County & State, or foreign country) D.C.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME SAMUEL FELDMAN						14. MOTHER'S MAIDEN NAME SARAH COHEN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. 577-48-266		17. INFORMANT Charita Niece			Address 8521 Beach Tree Rd. Bethesda, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Liver - Metastases 1561 DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH 12 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 7, 1966 to Jan 8, 1966 , that (I) (we) last saw the deceased alive on Jan 8, 1966 , and that death occurred at 10:45 PM from the causes and on the date stated above.											
22a. SIGNATURE Isidore Shulman						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) ISIDORE SHULMAN						22d. ADDRESS 915-19th ST. NW DC					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1/10/1966		23c. NAME OF CEMETERY OR CREMATORY HERRING RUN			23d. LOCATION (City, town or county) (State) BELTO MD				
24. FUNERAL DIRECTOR SYLVAN S. LEWIS & SON, Inc. 3319 OLYMPIA AVE.						25a. REC'D BY REGISTRAR JAN 11 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

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DEPARTMENT OF AGRICULTURE

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00925

00904

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN b. <u>21 hr.</u>		d. STREET ADDRESS <u>1669 Columbia Rd. N.W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Resmor Nursing Home & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mabel</u>	First <u>M.</u> Middle <u>M.</u> Last <u>Field</u>	4. DATE OF DEATH <u>Jan. 1 1966</u>	Month <u>Jan.</u> Day <u>1</u> Year <u>1966</u>
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/23/87</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>78</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel Grady</u>		14. MOTHER'S MAIDEN NAME <u>Mary T. O'Malley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>David B. Ward</u>		Address <u>3541-39th Street - Washington, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia - Right Lower Lobe -</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>cardiovascular Disease -</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1/1/1966</u>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>1/3/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Prince Georges County, Md.</u>
24. FUNERAL DIRECTOR <u>The S.H. Hines Co.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
2901 14th St. N.W. Washington, D.C.		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
		DATE <u>JAN 5 1966</u>	

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DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE REGISTRAR
WASHINGTON, D. C.

Birth Record
Name of Child
Date of Birth
Place of Birth
Sex
Race
Color
Religion
Parents' Names
Married Name of Mother
Occupation of Father
Occupation of Mother
Signature of Registrar
Date of Registration

[Redacted]

1/1/1961

1961

1/1/1961
1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington, D.C. b. COUNTY Washington, D.C. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington, D.C. d. STREET ADDRESS 910 Savannah Street, S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Neal Middle (none) Last Finlayson					4. DATE OF DEATH Month January Day 26 Year 19 66				
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 28 October 1959		9. AGE (In years last birthday) 6 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Maine		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Oscar W. Finlayson					14. MOTHER'S MAIDEN NAME Dolores Bernard				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record, The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis, Probable ? 962X DUE TO (b) Generalized Central Nervous system damage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Gunshot Wound INTERVAL BETWEEN ONSET AND DEATH 4 Days 10 Mons. 4 Yrs./ 10 Mons. 4 Yrs./									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that OK (this hospital) attended the deceased from July 22, 19 63 , to Jan. 26, 19 66 , that we last saw the deceased alive on January 26, 19 66 , and that death occurred at 10:05 from the causes and on the date stated above.									
22a. SIGNATURE <i>Larry E. Fleischmann</i> 22c. PHYSICIAN'S NAME (Type) Larry E. Fleischmann, MD					22b. DATE SIGNED 31 January 1966 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 2-9-66		23c. NAME OF CEMETERY OR CREMATORY HARMON		23d. LOCATION (City, town or county) (State) PR Geos Co, Md		
24. FUNERAL DIRECTOR CB Carroll Frazier			ADDRESS 389 R.I. AVE. N.W. Wash. D.C.		25a. REC'D BY REGISTRAR FEB 11 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

00028

Montgomery

Alabama

The Clinical Center, Bethesda 14, Md.

Head

(Name)

Elmington

Male

White

None

Genet. ... Elmington

No

None

The Clinical Center, Bethesda 14, Maryland

Genet. ... Elmington

Generalized Central Nervous System Damage

Unusual Sound

A 100%

A 100%

A 100%

January 20, 60

July 25, 60

Jan. 20, 60

X

Dr. W. H. H. H.

The Clinical Center, Bethesda 14, Md.

Dr. W. H. H. H.

Dr. W. H. H. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton c. LENGTH OF STAY IN b 1 day					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 15-1				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Univ. Nurs. Home 901 Arcola Ave. Wheaton Md.					d. STREET ADDRESS 8712 Colesville Rd. Sil. Sp. Md. e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
3. NAME OF DECEASED (Type or print) First Lucille Middle Margaret Last Fiora					4. DATE OF DEATH Month January Day 26 Year 19 66				
5. SEX F		6. COLOR OR RACE Caus.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 18, 1898		9. AGE (In years last birthday) 67 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Gerardi / Pasquale Gerardi					14. MOTHER'S MAIDEN NAME Julia (unknown) / Di Grazia				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Louis B. Fiora		Address 8712 Colesville Road Silver Spring, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF FLOOR OF MOUTH 143X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) } DUE TO (c) } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE 19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from JAN. 24, 1966 , to JAN. 26, 1966 , that (I) (we) last saw the deceased alive on JAN. 26, 1966 , and that death occurred at 5:00 P.M. , from the causes and on the date stated above.									
22a. SIGNATURE John H. Tuohy					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/27/66		
22c. PHYSICIAN'S NAME (Type) JOHN H. TUOHY, M.D.					22d. ADDRESS 7415 BRADLEY BLVD, BETHESDA, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-31-66		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		23d. LOCATION (City, town or county) (State) Arlington, Virginia			
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.		ADDRESS 8434 Georgia Avenue Silver Spring, Md.		25a. REC'D BY REGISTRAR FEB 3 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

2090

- 15 -

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

(M)

00928

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00906

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY-IN 1b <u>9 1/2 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> <u>15-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>			d. STREET ADDRESS <u>6905 Granby St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>EDITH</u> Middle <u>FISCHER</u> Last <u>FISCHER</u>			4. DATE OF DEATH Month <u>JAN</u> Day <u>30</u> Year <u>1966</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-1-1915</u>		9. AGE (In years last birthday) yrs. <u>50</u> IF UNDER 1 YEAR Months <u>5</u> Days <u>29</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (County & State, or foreign country) <u>Hammond Ind.</u>	
13. FATHER'S NAME <u>William Schmeuser</u>			14. MOTHER'S MAIDEN NAME <u>HECKNER</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Robert Fischer (husband)</u> Address <u>SAME</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 VENTRICULAR FIBRILLATION</u> DUE TO (b) <u>MYOCARDIAL INFARCTION</u> DUE TO (c) <u>CORONARY ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>					INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>5 YEARS</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>
21. I certify that (I) (this hospital) attended the deceased from <u>MAR. 29, 1959</u> to <u>JAN. 30, 1966</u> , that (I) (we) last saw the deceased alive on <u>JAN. 29, 1966</u> , and that death occurred at <u>5:30 AM</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>Robert G. Angle</u>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>JAN. 30, 1966</u>
22c. PHYSICIAN'S NAME (Type) <u>ROBERT G. ANGLE</u>			22d. ADDRESS <u>5009 Del Ray Ave., Bethesda, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u>	23b. DATE THEREOF <u>2-1-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ridgetown Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Gary, Indiana</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPH REY</u>			ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>FEB 4 1966</u>
			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

100000

RECEIPT OF DEATH

00000



4 1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00929

CERTIFICATE OF DEATH

00907

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>419 Fairmont Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>ELLA</u> Middle <u>R.</u> Last <u>Fisher</u>		4. DATE OF DEATH Month <u>JAN.</u> Day <u>3</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-24-1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>82</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Barton. Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Anthony Delwitt</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Macmillan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Son</u>		Address <u>8309 Melody Court</u> <u>Allan C. Fisher, Jr. Bethesda, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Arteriosclerotic cardiovascular disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>Sev. years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic cardiovascular disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>63</u> , to <u>2 Jan.</u> 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>2 Jan.</u> 19 <u>66</u> , and that death occurred at <u>4:45</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Horace W. Bernton</u>		22b. DATE SIGNED <u>1/3/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>HORACE W. BERNTON</u>		22d. ADDRESS <u>XXXX 4743 Bradley Blvd.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>Burial-transit 1-3-66</u>		<u>Sunset Mem. Cemetery</u>	<u>Cumberland, Maryland</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY</u>		25a. REC'D BY REGISTRAR <u>JAN 6 1966</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in a separate file, within 72 hours after death.

00907

00923

Albany

Cambridge

419. Belmont Lane

8200 Albany Court

Home, 7. 12. 1944, Albany, N.Y.

1944

KKKK 1944

1944-1945

1944-1945

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>12 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> <u>10-2</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center</u>					d. STREET ADDRESS <u>245 West 5th Street</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Linda</u>		First <u>Lou</u>		Middle <u>Fogle</u>		Last <u>Fogle</u>		4. DATE OF DEATH Month <u>January</u> Day <u>9</u> Year <u>1966</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 25, 1947</u>		9. AGE (in years last birthday) <u>18</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
1da. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				1db. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Glen A. Fogle</u>					14. MOTHER'S MAIDEN NAME <u>Helena Nusbaum</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>212-50-8740</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Widely metastatic malignant lymphoma</u> 2002 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>
2da. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				2db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <u>XX</u> (this hospital) attended the deceased from <u>December 28, 1965</u> to <u>January 9, 1966</u> , that <u>MD</u> (we) last saw the deceased alive on <u>January 9, 1966</u> , and that death occurred at <u>10:30 PM</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Theodore S. Zimmerman</u>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>10 January 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Theodore S. Zimmerman, M.D.</u>						22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/12/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Chapel</u>		23d. LOCATION (City, town or county) (State) <u>M. Libertytown Md.</u>			
24. FUNERAL DIRECTOR <u>Y.C. Barton, Walkersville, Md.</u>						25a. REC'D BY REGISTRAR <u>JAN 13 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

MEDICAL CERTIFICATION

00370

Rev. and Mrs. James

The Honorable

18

March 18

James

James

James

James

James

James

James

James

James

James

James

James

James

James

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00931

00910

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 17 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Haakon	First	Middle FOLLIE	Last LIEN
4. DATE OF DEATH January 3 19 66	Month	Day	Year
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 22, 1904
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY Engineer Navy Dept.	
11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Olaf Follie		14. MOTHER'S MAIDEN NAME Marit Larson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Audrey Smith		Address 105 Charles Dr. Bryn Mar, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia & Empyema 976X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) Cerebral Damage DUE TO (c) Gun-shot wound of Head			INTERVAL BETWEEN ONSET AND DEATH. 7 days 25 days 25 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot-Belt in head with 22 cal. Pistol.	
20c. TIME OF INJURY Month, Day, Year 8:30 a.m. 12/9 19 65	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Falls Church Fairfax Va.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John G. Ball		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 1/4/66	
EXAMINER'S NAME (Type) John G. Ball M. D.		22. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan. 7 1966	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	23d. LOCATION (City, town or county) (State) Arlington Virginia
24. FUNERAL DIRECTOR Pearson's Funeral Home		25a. REC'D BY REGISTRAR 1/4/66	
ADDRESS 472 N. Washington St Falls Church, Va.		25b. REGISTRAR'S SIGNATURE John Charles Judge	

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Washington

1015 10th Street

1015 10th Street

1015 10th Street

U. S. Naval Hospital

U. S. Naval Hospital

Washington

Washington

U. S. Naval Hospital

U. S. Naval Hospital

U. S. Naval Hospital

U. S. Naval Hospital

U. S. Naval Hospital

U. S. Naval Hospital

U. S. Naval Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
00932					CERTIFICATE OF DEATH					00908					
1. PLACE OF DEATH a. COUNTY <i>Mont.</i>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Mont.</i>										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>					c. LENGTH OF STAY IN 1b <i>D.O.A.</i>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>U.S. & Hospital</i>					d. STREET ADDRESS <i>8713 Plymouth ST.</i>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <i>Viola Anita Fones</i>					4. DATE OF DEATH Month Day Year <i>Jan. 29, 1966</i>										
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>21</i> <i>2-14-1916</i>		9. AGE (In years last birthday) <i>49</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Elect. Assembler</i>					10b. KIND OF BUSINESS OR INDUSTRY <i>Defense Elect.</i>					11. BIRTHPLACE (County & State, or foreign country) <i>Wash., D.C.</i>					
12. CITIZEN OF WHAT COUNTRY? <i>America</i>					13. FATHER'S NAME <i>Zach Lawson</i>					14. MOTHER'S MAIDEN NAME <i>MARtha Virginia Hickson</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>					16. SOCIAL SECURITY NO. <i>577-26-6567</i>					17. INFORMANT <i>PATRICIA Fones, Same</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive arteriosclerotic HS</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <i>months</i> <i>months</i>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from <i>1965</i> , to <i>1965</i> , that (I) (we) last saw the deceased alive on <i>1965</i> , and that death occurred at <i>5:00 PM</i> , from the causes and on the date stated above.															
22a. SIGNATURE <i>Abraham W. Darisat</i>										22b. DATE SIGNED <i>1-29-66</i>					
22c. PHYSICIAN'S NAME (Type) <i>ABRAHAM W. DARISAT</i>					22d. ADDRESS <i>1106 SPRING ST. S.S.</i>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>					23b. DATE THEREOF <i>2/1/66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln</i>			23d. LOCATION (City, town or county) (State) <i>Prince George Co., Md.</i>					
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home</i>										ADDRESS <i>1331 Rockville Pike Rockville, Md.</i>		25a. REC'D BY REGISTRAR <i>BBB 3</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 16 days		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Indiana		b. COUNTY Columbus		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital						d. STREET ADDRESS Route #7			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Jeanna Marie Foster		4. DATE OF DEATH January 26 1966		5. SEX Female		6. COLOR OR RACE Cauc.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 10, 1966	
9. AGE (In years last birthday) 16		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		11. BIRTHPLACE (County & State, or foreign country) Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John W. Foster		14. MOTHER'S MAIDEN NAME Wilmetta June Lawrence	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT John W. Foster		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital heart disease 7545 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that U (this hospital) attended the deceased from Jan. 10 , 19 66 , to Jan. 26 , 19 66 , that U (we) last saw the deceased alive on Jan. 26 , 19 66 , and that death occurred at 213 M. from the causes and on the date stated above. 22a. SIGNATURE R. F. Swanger 22c. PHYSICIAN'S NAME (Type) R. F. Swanger, M. D. 22b. DATE SIGNED Jan. 27, 1966 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md. 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 1-28-66 23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery 23d. LOCATION (City, town or county) (State) Arlington Virginia 24. FUNERAL DIRECTOR R. A. Pumphrey 25a. REC'D BY REGISTRAR FEB 4 1966 25b. REGISTRAR'S SIGNATURE Charles Judge					

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Indians

Indians

(1900)

U. S. Navy Hospital

U. S. Navy Hospital

Doctor

Doctor

January 1, 1900

January 1, 1900

Belmont, Maryland

John W. Hester

Belmont, Maryland

John W. Hester, Belmont, Md.

John W. Hester

Confidential Agent

John W. Hester

1900

1900

1900

1900

1900

1900

1900

1900

U. S. Navy Hospital, Belmont, Md.

U. S. Navy Hospital, Belmont, Md.

Virginia

U. S. Navy Hospital, Belmont, Md.

U. S. Navy Hospital, Belmont, Md.

U. S. Navy Hospital, Belmont, Md.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Item 206 Film G373 2/10/66 mm

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00934

00912

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase - 15 - 1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Montgomery County Air Port.</u>				d. STREET ADDRESS <u>3205 Woodbine St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Norman</u> Middle <u>Alvin</u> Last <u>Freudberg</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>16</u> Year <u>1966</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 17, 1921</u>	
9. AGE (in years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>LIQUOR</u>		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>ISIDORE FREUDBERG</u>			
14. MOTHER'S MAIDEN NAME <u>MINNIE GREENBERG</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes give war or dates of service) <u>WWII</u>			
16. SOCIAL SECURITY NO. <u>577-18-6278</u>				17. INFORMANT - Address <u>BARBARA LEE FREUDBERG AS 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laceration & maceration of Brain.</u> 864X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Trauma from Aircraft Prop.</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>When cranking plane by propeller, slipped and blade struck his head.</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>Jan 16 1966</u> p.m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Air Port.</u>	
20f. (City or town) (County) (State) <u>Gaithersburg Montgomery Md</u>				21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 1/16/66 Address (Street, city, town, or county) <u>Montgomery</u>			
22. DATE SIGNED				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
23b. DATE THEREOF <u>1-18-66</u>				23c. NAME OF CEMETERY OR CREMATORY <u>NAT'L MEM. PARK</u>			
23d. LOCATION (City, town or county) (State) <u>FALLO CHURCH VA</u>				24. FUNERAL DIRECTOR <u>GOLDBERG FUNERAL HOME 4217 9th St. N.W.</u>			
25a. REC'D BY REGISTRAR DATE <u>JAN 20 1966</u>				25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

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VR A15 (4)
20M 1/65

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00913

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) b. STATE Pennsylvania	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairfield	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS Box 102	
3. NAME OF DECEASED (Type or print) First Carl Middle Alfred Last FROGNER		4. DATE OF DEATH Month January Day 27 Year 19 66	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 28, 1926
9. AGE (In years last birthday) 39 yrs.		10. IF UNDER 1 YEAR Months 39 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Carrington, N. Dakota		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Frogner		14. MOTHER'S MAIDEN NAME Emma Peters	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W.W. 2 536 20 7775	
17. INFORMANT Mrs. Betty A. Frogner, Box 102, Fairfield		Address Pennsylvania	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of the Lung with widespread metastases 163+ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 28 , 19 65 , to Jan. 27 , 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Jan. 27 19 66 , and that death occurred at 12:48 P.M. from the causes and on the date stated above.			
22a. SIGNATURE F. C. Johnson		22b. DATE SIGNED Jan. 27, 1966	
22c. PHYSICIAN'S NAME (Type) F. C. Johnson, M.D.		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 31, 1966	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Va.	
24. FUNERAL DIRECTOR Wilson Funeral Home, Emmittsburg, Md.		25a. REC'D BY REGISTRAR FEB 1 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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U. S. Naval Hospital, Bethesda, Md.
JAN 28 1945
JAN 28 1945
JAN 28 1945

U. S. Naval Hospital, Bethesda, Md.
JAN 28 1945
JAN 28 1945
JAN 28 1945

U. S. Naval Hospital, Bethesda, Md.
JAN 28 1945
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U. S. Naval Hospital, Bethesda, Md.
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00936											
00914											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Ma</u> b. COUNTY <u>Montg</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kensington Gardens</u>					d. STREET ADDRESS <u>7405 - Birch Ave</u>						
3. NAME OF DECEASED (Type or print) First <u>Isaac</u> Middle <u>D</u> Last <u>FURLOW</u>					4. DATE OF DEATH Month <u>Jan</u> Day <u>26</u> Year <u>1966</u>						
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR. 10, 1879</u>		9. AGE (In years last birthday) <u>86</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (Country & State, or foreign country) <u>MARYLAND</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				
13. FATHER'S NAME <u>Thomas J Furlow</u>					14. MOTHER'S MAIDEN NAME <u>Virginia Rice</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>					16. SOCIAL SECURITY NO. <u>----</u>						
17. INFORMANT <u>Nursing Home Records</u>					Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary Occlusion</u> 4201 DUE TO <u>Chylous Myocarditis Cornary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Glomerulonephritis</u> (c) <u>Glomerulonephritis</u>										INTERVAL BETWEEN ONSET AND DEATH <u>modern</u> <u>12/12/65</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>9/21/1944</u> to <u>1/26/1966</u> , that (I) (we) last saw the deceased alive on <u>1/21/66</u> , and that death occurred at <u>3:30</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Howard T Mourse</u>					22b. DATE SIGNED <u>1/26/66</u>			22c. PHYSICIAN'S NAME (Type) <u>Howard T Mourse M.D.</u>			
22d. ADDRESS <u>7030 Lanall Ave Takoma Park Md</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>			23b. DATE THEREOF <u>1/29/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Prince Georges County, Md</u>			
24. FUNERAL DIRECTOR <u>The S.H. Hines Co.</u>					ADDRESS <u>2901 14th ST. NW.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 1 1966</u>				
					25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>						

11830

00330

CERTIFICATE OF DEATH

Montgomery
Residence
Cause of Death
Date of Death
Place of Death
Signature of Doctor
Signature of Registrar
Signature of Coroner
Signature of Medical Examiner
Signature of Burial Officer
Signature of Minister of Religion
Signature of Undertaker
Signature of Funeral Home
Signature of Cemetery
Signature of Interment
Signature of Burial
Signature of Cremation
Signature of Other

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN b 2 weeks d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 13003 Twinbrook Parkway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) John R. Fyfe			4. DATE OF DEATH January 11 1966		5. SEX Male			6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 27, 1905		9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 15 Days 1		IF UNDER 24 HRS. Hours 19 Min. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maint. Supt.			10b. KIND OF BUSINESS OR INDUSTRY Housing		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Andrew Fyfe			14. MOTHER'S MAIDEN NAME Anusilla Mackie						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. 172-14-6079		17. INFORMANT Roy Bossi, Windber, Pa.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 5020 OUE TO (b) Emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Bronchitis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH 2 weeks 5 years years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 5		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1/17/66 19, to 1/11/66 19, that (I) (we) last saw the deceased alive on 1/11/66 19, and that death occurred at 2:55 M, from the causes and on the date stated above.									
22a. SIGNATURE John J. Curry, M.D.					22b. DATE SIGNED 1/11/66		22c. PHYSICIAN'S NAME (Type) John J. Curry, M.D.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 1/14/66		23c. NAME OF CEMETERY OR CREMATORY RICHLAND		23d. LOCATION (City, town or county) (State) RICHLAND TOWNSHIP, PA.		
24. FUNERAL DIRECTOR W.W. CHAMBERS CO. INC.					25a. REC'D BY REGISTRAR 1400 CHAPIN ST. WASH. D.C. 20004		25b. REGISTRAR'S SIGNATURE Charles Judge		

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00938

00918

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>Washington, D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C. 47-3</u>	
c. LENGTH OF STAY IN 1b <u>47 days</u>		d. STREET ADDRESS <u>1727 Mass Ave. NW</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Hedvig C. M.</u> Middle <u>Golinski</u> Last <u></u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>9</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/6/10</u> 9. AGE (In years last birthday) <u>66</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife - Retired State Dept.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (County & State, or foreign country) <u>Poland</u>
13. FATHER'S NAME <u>Leon SIELKI</u>		14. MOTHER'S MAIDEN NAME <u>Tillich - BARBARA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>079-28-9717</u>	
17. INFORMANT <u>Adam J. Golinski - odd same</u> Address <u></u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory insufficiency</u> 1621 DUE TO <u>BRONCHOGENIC RIGHT LUNG CARCINOMA</u> (b) <u>With MEDIASTINAL, LEFT LUNG, LEFT TEMPORO-PARIETAL</u> (c) <u>BRAIN METASTASES</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that (I) (this hospital) attended the deceased from <u>11/23</u> , 19 <u>65</u> , to <u>1/9</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1/8</u> , 19 <u>65</u> , and that death occurred at <u>1:47</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Stanley A. Radvan-Ziemnowicz</u>		22b. DATE SIGNED <u>1/9/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>STANLEY A. RADVAN-ZIEMNOWICZ MD</u>		22d. ADDRESS <u>6120 Massachusetts Ave. Wash DC 20016</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>1/12/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVE</u>	23d. LOCATION (City or Town) (County) (State) <u>WASHINGTON, D.C.</u>
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS CO.</u>		25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u></u>		DATE <u>JAN 13 1966</u>	

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RECEIVED IN DEPT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00939						00919					
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CHEVY CHASE</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CHEVY CHASE</u> 15-1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>124-QUINCY ST.</u>						d. STREET ADDRESS <u>124-QUINCY ST.</u>					
3. NAME OF DECEASED (Type or print) <u>DR. JOHN</u> First <u>HALL</u> Middle <u>GENAU</u> Last						4. DATE OF DEATH <u>JAN. 6TH</u> 19 <u>66</u> Month Day Year					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 18, 1910</u>		9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DENTIST</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>DENTISTRY</u>		11. BIRTHPLACE (County & State, or foreign country) <u>WASH. D.C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>ALOYSIUS T. GENAU</u>						14. MOTHER'S MAIDEN NAME <u>MARGARET HALL</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>579-52-6548</u>		17. INFORMANT <u>WIFE - 1-0</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>CORONARY THROMBOSIS</u> 4201 DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>CONGESTIVE HEART FAILURE</u> 2 yrs 2 yrs										INTERVAL BETWEEN ONSET AND DEATH <u>NONE</u> <u>2 yrs</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE</u> , 19 <u>64</u> , to <u>JAN. 6</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1/4</u> 19 <u>66</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>William T. Saccardi</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/6/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>William T. Saccardi</u>						22d. ADDRESS <u>1150 CONN AVE. NW WASH DC</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county) (State)			
<u>BURIAL</u>		<u>1-10-66</u>		<u>MT. OLIVET CEMETERY</u>				<u>WASH. D.C.</u>			
24. FUNERAL DIRECTOR <u>Thomas B. Hannon</u>						ADDRESS <u>WASH. D.C.</u>		25a. REC'D BY REGISTRAR <u>DATE</u>		25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>	
						<u>JAN 14 1966</u>					

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton c. LENGTH OF STAY IN b 3 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 5010 Macon Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Beatrice Middle P Last Gibson		4. DATE OF DEATH Month 1 Day 20 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/17/1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.
13. FATHER'S NAME William H. Parker		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		17. INFORMANT LLOYD W. GIBSON Address SAME AS #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrosin of Liver 5810 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July , 19 65 , to Jan , 19 66 , that (I) (we) last saw the deceased alive on Jan 19 , 19 66 , and that death occurred at 9:45 M., from the causes and on the date stated above.			
22a. SIGNATURE Bernard A. Fitzgerald		22b. DATE SIGNED 1-20-66	
22c. PHYSICIAN'S NAME (Type) BERNARD A. FITZGERALD		22d. ADDRESS 417 UNIV. BLVD. E. SILVER SP. MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 1-24-66	23c. NAME OF CEMETERY OR CREMATORY MT OLIVET CEMETERY	23d. LOCATION (City, town or county) (State) WASHINGTON D. C.
24. FUNERAL DIRECTOR Francis J. Collins		25a. REC'D BY REGISTRAR JAN 24 1966	25b. REGISTRAR'S SIGNATURE J. Charles Judge

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REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE

WASHINGTON

1-24-00

GENERAL

RECEIVED JAN 24 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
00941						00921						
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MARYLAND</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross of Silver Spring</u>						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg, Maryland</u> d. STREET ADDRESS <u>18 Hutton Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>John M. Gloyd</u>			4. DATE OF DEATH Month <u>1</u> Day <u>1</u> Year <u>1966</u>			5. SEX <u>Male</u>			6. COLOR OR RACE <u>White</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			8. DATE OF BIRTH <u>1/12/00</u>			9. AGE (In years last birthday) <u>65</u> yrs.			IF UNDER 1 YEAR Months <u>6</u> Days <u>5</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>"</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Edmond Gloyd</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Arnold</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>"</u>			
17. INFORMANT <u>Dr. Russell</u>			Address <u>169 Buckle St.</u>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture of myocardium</u> 4201 DUE TO <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Coronary artery disease</u> DUE TO <u>Heart disease</u> (c) <u>Unknown</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>55 hours</u> <u>Unknown</u>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>3:47</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 30</u> , 19 <u>65</u> , to <u>Jan 1</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Jan 1</u> , 19 <u>66</u> , and that death occurred at <u>3:47 PM</u> , from the causes and on the date stated above.												
22a. SIGNATURE <u>Arson H. Traum</u>						22b. DATE SIGNED <u>January 2 1966</u>			22c. PHYSICIAN'S NAME (Type) <u>ARSON H. TRAUM</u>			
22d. ADDRESS <u>8237 Georgia Ave Silver Spring Maryland</u>						23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						
23b. DATE THEREOF <u>Jan 5, 1966</u>						23c. NAME OF CEMETERY OR CREMATORY <u>St. Rose Cemetery</u>						
23d. LOCATION (City, town or county) (State) <u>Clippers, Md.</u>						24. FUNERAL DIRECTOR <u>Charles Judge</u>						
25a. REC'D BY REGISTRAR <u>Charles Judge</u>						25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>						
DATE <u>JAN 5 1966</u>												

1860

1860



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montgomery General Hospital					d. STREET ADDRESS 17111 Old Baltimore Road					
3. NAME OF DECEASED (Type or print) Edith Ruby Robbins Godshalk					4. DATE OF DEATH January 30 19 66					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/5/88		9. AGE (In years) 78 yrs. IF UNDER 1 YEAR 0 Months 25 Days 0 Hours 0 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife					10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (County & State, or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Samuel Robbins					14. MOTHER'S MAIDEN NAME unknown Branson					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. unknown		17. INFORMANT Hospital records					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4201 DUE TO (b) Coronary Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Coronary Atherosclerosis INTERVAL BETWEEN ONSET AND DEATH 2 hrs 5 yrs 5 yrs.										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus.										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1955 , to Jan 26, 1966 , that (I) (we) last saw the deceased alive on 1/20/66 19 66 , and that death occurred at 9:45 A.M. from the causes and on the date stated above.										
22a. SIGNATURE Richard A. Yates					22b. DATE SIGNED 1/31/66					
22c. PHYSICIAN'S NAME (Type) Richard A. Yates MD					22d. ADDRESS Olney, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial-transit			23b. DATE THEREOF 2/3/66		23c. NAME OF CEMETERY OR CREMATORY Birmingham Lafayette		23d. LOCATION (City, town or county) (State) West Chester, Pa.			
24. FUNERAL DIRECTOR Robert A. Pumphrey					25a. REC'D BY REGISTRAR FEB 7 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00943

00917

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>28 days</u>		
d. NAME OF HOSPITAL OR INSTITUTION. (If not in hospital, give street address) <u>70 Suburban Hospital</u>			d. STREET ADDRESS <u>4618 Norwood Drive</u>		
3. NAME OF DECEASED (Type or print) First <u>Bertie</u> Middle <u>Lane</u> Last <u>Goebel</u>			4. DATE OF DEATH Month <u>JAN</u> Day <u>15</u> Year <u>1966</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 20, 1891</u>		9. AGE (In years last birthday) <u>74</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT <u>Husband - Louis</u> Address <u>Same</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>416x CONGESTIVE HEART FAILURE</u> DUE TO (b) <u>CHRONIC RHEUMATIC HEART DISEASE</u> DUE TO (c) <u>BRONCHOPNEUMONIA</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Weeks</u> <u>YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12-30, 1956</u> , to <u>1-15, 1966</u> , that (I) (we) last saw the deceased alive on <u>1-14, 1966</u> , and that death occurred at <u>3:00 AM</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>Michel M Healy</u>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-15-66</u>
22c. PHYSICIAN'S NAME (Type) <u>MICHEL M HEALY, MD</u>			22d. ADDRESS <u>WASHINGTON CLINIC, WASH, DC</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/18/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince George County, Md.</u>	
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		ADDRESS <u>7557 Wisconsin Ave. Bethesda</u>		25a. REC'D BY REGISTRAR <u>AN 19 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

10017

DEPARTMENT OF HEALTH

10017

Name of Patient		Date of Birth	
Address		City	
State		County	
Occupation		Religion	
Marital Status		Education	
Previous Illnesses		Present Illness	
Treatment		Prognosis	
Signature of Physician		Signature of Nurse	
Date		Time	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b Chevy Chase 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5038 Park Place		d. STREET ADDRESS 5038 Park Place	
3. NAME OF DECEASED (Type or print) CLARA EDITH GRAVES		4. DATE OF DEATH Jan. 17 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 14, 1893
9. AGE (in years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Govt. worker		10b. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (County & State, or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Walter		14. MOTHER'S MAIDEN NAME Emma Edith Engel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 579-60-7577	
17. INFORMANT Mrs. E. T. McKnight		Address 5038 Park Pl. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction partial 157X DUE TO (b) Malignancy of Pancreas Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) DIABETES			INTERVAL BETWEEN ONSET AND DEATH 2 weeks ? Since 1942
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES Generalized Arteriosclerosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. I 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 28, 1942, to Jan 17, 1966, that (I) (we) last saw the deceased alive on 19, and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE Alma Jane Speer		22b. DATE SIGNED Jan. 17, 1966	
22c. PHYSICIAN'S NAME (Type) ALMA JANE SPEER		22d. ADDRESS 3232 Garfield St NW	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 1-19-1966	
23c. NAME OF CEMETERY OR CREMATORY Presbyterian Cemetery Alexandria Va.		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. Wash. DC.		25a. REC'D BY REGISTRAR JAN 19 1966	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

MEDICAL CERTIFICATION

2300

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VR A15ME
3500 4-64

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Md. b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park 16-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash. San. + Hosp		d. STREET ADDRESS 8110 Hammond Ave	
3. NAME OF DECEASED (Type or print) Edward Frederick Grune		4. DATE OF DEATH Month Jan Day 9 Year 1966	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 11, 1916
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Breyer Ice Cream	
11. BIRTHPLACE (State or foreign country) Hartsdale, New York		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Edward F. GRUNE		14. MOTHER'S MAIDEN NAME MARGARET KINGSLEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. W.W. II	
17. INFORMANT MRS. MARIE M. GRUNE (WIFE)		Address SAME AS #2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial insufficiency 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery heart disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Read	CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 11/10/66
EXAMINER'S NAME (Type) BELDEN R. READ	Address (Street, city, town, or county) 1110/66		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan. 13, 1966	23c. NAME OF CEMETERY OR CREMATORY Fair Lincoln Cemetery	23d. LOCATION (City, town or county) (State) Belmar Manor Park Co. Md
24. FUNERAL DIRECTOR John H. Harts		ADDRESS 254 Canal N.W. - DC	25. REC'D BY REGISTRAR DATE JAN 13 1966
		25b. REGISTRAR'S SIGNATURE John Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00946

CERTIFICATE OF DEATH

00924

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>11 1/2 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>14000 Crest Hill Lane</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 15-1 d. STREET ADDRESS <u>14000 Crest Hill Lane</u>			
3. NAME OF DECEASED (Type or print) <u>RAYMOND LESLIE GUSTAFSON</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>6</u> Year <u>1966</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 3 - 1920</u>		9. AGE (In years last birthday) <u>45</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TYPOGRAPHY</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MAYFIELD HEIGHTS, OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>CARL GUSTAFSON</u>				14. MOTHER'S MAIDEN NAME <u>DAGNY WHICKLAND</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes give war or dates of service) <u>1940 TO 45</u>		16. SOCIAL SECURITY NO. <u>579-10-5830</u>		17. INFORMANT Address <u>14000 CREST HILL LANE SILVER SPRING</u> <u>GUSTAFSON</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the stomach</u> <u>15-1X</u> DUE TO <u>with metastasis to liver</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause last. DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 4</u> 19 <u>66</u> to <u>Jan 6</u> 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>Jan 4</u> 19 <u>66</u> and that death occurred at <u>11:42 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Ronald S. Fleischer</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-6-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>RONALD S. FLEISCHER, M.D.</u>				22d. ADDRESS <u>7411 BIGGS Rd HYATTSVILLE Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-10-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, Inc.</u>				ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 13 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

32300

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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00947

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00925

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Quantico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Quantico 83-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital			d. STREET ADDRESS MOQ 196, Marine Corps Schools		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First James Middle Richard Last Hadd			4. DATE OF DEATH Month January Day 22 Year 1966		
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 24, 1945	9. AGE (In years last birthday) 20 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) St. Paul, Minnesota	
13. FATHER'S NAME Harry A. Hadd			14. MOTHER'S MAIDEN NAME Helen R. Haeusler		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Harry A. Hadd, Quantico, Virginia	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Leukemia 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that the (this hospital) attended the deceased from Jan. 18, 1966 to Jan. 22, 1966 , that he (we) last saw the deceased alive on Jan. 22, 1966 , and that death occurred at 6:25 AM , from the causes and on the date stated above.					
22a. SIGNATURE Francis C. Johnson			22b. DATE SIGNED Jan. 22, 1966		
22c. PHYSICIAN'S NAME (Type) U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/25/66	23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia
24. FUNERAL DIRECTOR R. Murphy, Arlington, Virginia			25a. REC'D BY REGISTRAR JAN 26 1966		
			25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Medical Examiner Notified - Dr. B. B. Sharp

MEDICAL CERTIFICATION

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b 1 hr d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 9211 Mintwood Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Katherine First Middle Last 9. Hampton		4. DATE OF DEATH Month Day Year 1/17/66 19	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 11/6/65
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Washington, D.C.
13. FATHER'S NAME John L. Hampton		14. MOTHER'S MAIDEN NAME Constance Cairns	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT John Hampton, Silver Spring, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Asphyxiation due to suffocation by crib-blanket. DUE TO (b) 9240 DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Infant's head & face covered by child-blanket	
20c. TIME OF INJURY Month, Day, Year 7:15 a.m. - 1-17-66	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Silver Spring Montgomery Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		22. DATE SIGNED 1-17-1966	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1-19-66	23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery	23d. LOCATION (City or Town) (County) (State) Arlington, Virginia
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.		25. REC'D BY REGISTRAR Charles Judge DATE JAN 24 1966	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Items 18-21 Film G37 **MARYLAND STATE DEPARTMENT OF HEALTH**
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00949 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** **00927**

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Toboma Park</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash Saint Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> 16-2 d. STREET ADDRESS <u>5407 Sargent Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Bearah Oates</u> Middle <u>Hardy</u> Last <u>Hardy</u>				4. DATE OF DEATH Month <u>1</u> Day <u>25</u> Year <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-23-11</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cafeteria Worker Sch. Capet.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Hampshire Co. W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Clatus Oates</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Good</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. <u>226-09-8088</u>		17. INFORMANT <u>Hus. - Mr. Frank M. Hardy</u>		Address <u>Hyattsville</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple, extreme, injuries with massive</u> 8304 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>exsanguination.</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Deceased crushed against building by car moving in reverse.</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>2:25</u> p.m. <u>1/25</u> 19 <u>66</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>School yard</u>		20f. (City or town) (County) (State) <u>Chillum Pr. Geo. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Reap</u>				22. DATE SIGNED <u>JAN. 25, 1966</u>			
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>				Address (Street, city, town, or county) <u>Frederick Co. Va.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-29-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Old Stone Church Cem.</u>		23d. LOCATION (City, town or county) (State) <u>FREDERICK Co. Va.</u>	
24. FUNERAL DIRECTOR <u>Warner E. Thompson Inc</u>				25a. REC'D BY REGISTRAR <u>Feb 2 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00950

00928

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>6 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>15-1</u> d. STREET ADDRESS <u>2319 Blyeridge Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CATHERINE A. HARMON</u> First Middle Last 4. DATE OF DEATH <u>JAN. 31 1966</u> Month Day Year		5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife RET. OPERATOR</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Telephone Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>PENNA.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George J. Haber</u>		14. MOTHER'S MAIDEN NAME <u>Mary U. McGroary</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>577-01-2246</u>	
17. INFORMANT <u>John G. Thompson</u> Address <u>2356 Glenmont Circle Wheaton, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mucinous Adenocarcinoma with</u> <u>199.2</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>metastasis. Primary unknown</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-31-66</u> , 19 <u>66</u> , to <u>1-31-66</u> , 19 <u>66</u> , that (I) <u>we</u> last saw the deceased alive on <u>1-31</u> 19 <u>66</u> , and that death occurred at <u>8 p</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Morris Perry</u>		22b. DATE SIGNED <u>1-31-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Morris Perry</u>		22d. ADDRESS <u>11602 Georgia Avenue, Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-4-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>John E. Pumphrey, Inc.</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>John E. Pumphrey</u> 25b. REGISTRAR'S SIGNATURE <u>John E. Pumphrey</u>	
DATE <u>FEB 7 1966</u>			

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DATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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00929

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>8th. 15min</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>3588 Ireland Street</u>			
3. NAME OF DECEASED (Type or print) <u>Ruth P. Harper</u>				4. DATE OF DEATH <u>Jan. 23 1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-27-1890</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Penna</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>John Polkinghorn</u>			
14. MOTHER'S MAIDEN NAME <u>Laura E. Yost</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>			
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>James P. Harper - Husband</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> 331X DUE TO (b) <u>arteriosclerosis generalized</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>(the)</u> hospital attended the deceased from <u>Nov. 1953</u> , to <u>Jan 23, 1966</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>Jan 23 1966</u> , and that death occurred at <u>10:30 P.M.</u> from causes on and on the date stated above.							
22a. SIGNATURE <u>Alfred S. Norton</u>				22b. DATE SIGNED <u>1/23/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Alfred S. Norton M.D.</u>				22d. ADDRESS <u>7710 Dwight Pr. Bethesda Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
<u>Buried</u>		<u>1-27-1966</u>		<u>Fort Lincoln Cemetery</u>		<u>Prince Georges Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>				25a. REC'D BY REGISTRAR <u>Jan 26 1966</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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RECEIVED BY DEPT. OF AGRICULTURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
00952					00930				
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 14 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hollywood 18-2				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital					d. STREET ADDRESS Route #1, Box 28			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lori			First Lori Middle Ann Last HART		4. DATE OF DEATH Month January Day 24 Year 1966				
5. SEX Female		6. COLOR OR RACE Cauc.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 19, 1964		9. AGE (In years last birthday) 1 yrs.	
						IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Patuxent River, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Glenn B. Hart					14. MOTHER'S MAIDEN NAME Norma Moore				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Glenn B. Hart Address Route 1, Box 28, Hollywood, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7547 Congenital heart disease, transposition of great vessels. DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (it) (this hospital) attended the deceased from Jan. 10, 1966 to Jan. 24, 1966 , that (it) (we) last saw the deceased alive on Jan. 24, 1966 , and that death occurred at 3:10 PM from the causes and on the date stated above.									
22a. SIGNATURE <i>[Signature]</i>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Jan. 25, 1966		
22c. PHYSICIAN'S NAME (Type) J. I. Lynch					22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 1-27-1966		23c. NAME OF CEMETERY OR CREMATORY Westview		23d. LOCATION (City, town or county) (State) Radford, Virginia		
24. FUNERAL DIRECTOR Mattingly Funeral Home ADDRESS 131 11th St., S.E. Washington, D. C.					25a. REC'D BY REGISTRAR JAN 26 1966		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
c. LENGTH OF STAY in 1b <u>1 WEEK</u>		d. STREET ADDRESS <u>2240 Observatory Pl. N.W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CHEVY CHASE NURSING AND CONVALESCENT CENTER</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>THOMAS E. (HARTY) HARTY</u>		4. DATE OF DEATH <u>JAN. 28 1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 9, 1884</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Charles County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES HARTY</u>		14. MOTHER'S MAIDEN NAME <u>COPSEY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>578 50 0102</u>	
17. INFORMANT <u>Washington, 2240 Observatory Pl</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia</u> DUE TO <u>Carcinoma of Sall Bladder</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastases to Liver</u> (c) <u>Metastases to Liver</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 15</u> , 19 <u>65</u> , to <u>Jan 28</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>Jan 27</u> , 19 <u>66</u> , and that death occurred at <u>11:40 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. E. Stewart Lyddane</u>		22b. DATE SIGNED <u>1/28/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. E. Stewart Lyddane</u>		22d. ADDRESS <u>3066 - Quad - 9 C</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1-31-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>WASH D.C.</u>
24. FUNERAL DIRECTOR <u>Robert A. DeVoe</u>		25a. REC'D BY REGISTRAR <u>FEB 3 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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CERTIFICATE OF DEATH

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Blank certificate form with horizontal lines for text entry.

THE AMERICAN SOCIETY OF
MUTUAL LIFE ASSURANCE CO.
OF NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

BPD - Clearance given per Dr. Ball - done

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>18 hrs 45 mins</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring 15-1</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Suburban Hosp.</i>						d. STREET ADDRESS <i>13116 Brook Lutes Ave Dr.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>MARY</i>		Middle <i>Ann</i>		Last <i>HAUSCHILD</i>		4. DATE OF DEATH Month <i>JAN</i>		Day <i>21</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3/17/1879</i>		9. AGE (In years last birthday) <i>86</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Latham, Kansas KANSAS</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>ISAAC VAN MATRE</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>455-01-6612</i>		17. INFORMANT <i>FRED HAUSCHILD - same husband</i>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>5703 Acute intestinal obstruction</i> DUE TO (b) <i>Volvulus, ileum</i> DUE TO (c) <i>5 days</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that 4 (this hospital) attended the deceased from <i>1/21</i> , 19 <i>66</i> , to <i>1/21</i> , 19 <i>66</i> , that 4 (we) last saw the deceased alive on <i>1/21</i> 19 <i>66</i> , and that death occurred at <i>5:30</i> P.M., from the causes and on the date stated above.											
22a. SIGNATURE <i>Fredrick Y. Donn</i>										22b. DATE SIGNED <i>1/22/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>FREDERICK Y. DONN</i>										22d. ADDRESS <i>800 Pershing Drive Silver Sp</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Jan. 24, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>				23d. LOCATION (City, town or County) (State) <i>Rockville, Maryland Md</i>			
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>				ADDRESS <i>8434 Georgia Avenue Silver Spring, Md.</i>				25a. REC'D BY REGISTRAR <i>JAN 26 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00955

00933

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Hall Sanitarium 10231 Carroll Pl.				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Dist. of Col. b. COUNTY Washington 47-3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS 6330 32nd St. N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Florence E. Harworth.		First Middle Last		4. DATE OF DEATH Month January Day 5 Year 1966			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-16-1872		9. AGE (In years last birthday) 93 yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS: Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Thomas Ellis				
14. MOTHER'S MAIDEN NAME Alice Virginia Wilson			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) - - - 16. SOCIAL SECURITY NO. 578-66-8836 17. INFORMANT Ross Harworth Address Wash. DC. 6330 32nd St. N.W.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 4201 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last, (b) myocardial ischemia DUE TO (c) Arteriosclerosis, Generalized					INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 2 yrs. 20 yrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) - - -					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) - - -		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) - - -					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1950, 19, to 1/5, 1966, that (I) (we) last saw the deceased alive on 1/3, 1966, and that death occurred at 6:30 A.M. from the causes and on the date stated above.							
22a. SIGNATURE PHYSICIAN'S NAME (Type) S.A. Thomas M.D.				22b. DATE SIGNED 1/5/66			
22c. ADDRESS 4301 48th St. N.W.; Wash D.C.				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-7-1966		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			
23d. LOCATION (City, town or county) Suitland, Md. (State)		24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave. N.W. Washington, DC.					
25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE 			

MEDICAL CERTIFICATION

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1st. of Oct.

1st. of Oct.

Washington

Washington

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1-15-1933

1-15-1933

Commence

Thomas Ellis

Alice Virginia Wilson

178-2-30000

178-2-30000

SA Thomas, mo.

178-2-30000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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00956

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00934

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria 83-3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>903 S. Washington St</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>A.</u> Last <u>Hayden</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>19</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/1/92</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>3</u>		IF UNDER 24 HRS. Hours <u>73</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Southern Railway</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Alis. Va.</u>	
13. FATHER'S NAME <u>John T.</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ellen Lyons</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Lucile H. Padgett</u> Address <u>903 S Washington St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>							
5721 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ruptured diverticulum, sigmoid colon and localized peritonitis</u>							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Siderocytic anemia</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>65</u> , to <u>Jan 19</u> , 19 <u>66</u> that (I) <u>was</u> last saw the deceased alive on <u>Jan 19</u> , 19 <u>66</u> , and that death occurred at <u>8:11</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>John Daniel Wilkes</u>						22b. DATE SIGNED <u>JAN 20, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>J DANIEL WILKES</u>						22d. ADDRESS <u>8600 Old Georgetown Rd. Bethesda Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/22/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Alexandria, Virginia</u>	
24. FUNERAL DIRECTOR <u>Remains Funeral Home Alexandria</u>				25a. REC'D BY REGISTRAR <u>Jan 24 1966</u>		25b. REGISTRAR'S SIGNATURE <u>John L. Judge</u>	

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OFFICE OF THE SECRETARY

1933

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>1</p> <p>00957</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>00935</p> </div> </div>											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>						c. LENGTH OF STAY IN 1b <u>Poolsville, Md</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Neaton</u>						4. DATE OF DEATH Month <u>January</u> Day <u>5</u> Year <u>1966</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 5, 1966</u>		9. AGE (In years last birthday) yrs. <u>40</u>		IF UNDER 1 YEAR Months <u>40</u> Days <u>40</u> Hours <u>40</u> Min. <u>40</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Co., Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Neaton, Guy Lester</u>						14. MOTHER'S MAIDEN NAME <u>Burress, Delores Ann</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 776X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>1 lb 3 oz 14 in 20 wks</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
INTERVAL BETWEEN ONSET AND DEATH											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1/5</u> , 19 <u>66</u> , to <u>1/5</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1/5</u> , 19 <u>66</u> , and that death occurred at <u>5:20</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Harold M. Hobart</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>HAROLD M. HOBART</u>						22d. ADDRESS <u>5402 Conn. ave. Wash, D.C.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>1/6/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hospital</u>				23d. LOCATION (City, town or county) (State) <u>Bethesda - Montgomery - MD</u>			
24. FUNERAL DIRECTOR <u>MRS. Amelia C. Carter</u> <u>Administrator (SA)</u>						ADDRESS <u>Suburban Hospital</u>		25a. REC'D BY REGISTRAR <u>JAN 11 1966</u>		25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>	

6-168450

00221

00221

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1 - CLEARED WITH DR. REAP DME. 1-2-66

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00958 CERTIFICATE OF DEATH O.K'd by Coroner 00936											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			c. LENGTH OF STAY IN 1b <u>5 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			15-1			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4805 Tallahassee Avenue</u>					d. STREET ADDRESS <u>4805 Tallahassee</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Edith</u> First		<u>Eleanor</u> Middle		<u>Hein</u> Last		4. DATE OF DEATH <u>January</u> Month <u>2</u> Day <u>19</u> Year <u>66</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 7, 1888</u>		9. AGE (In years last birthday) <u>77</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Seymour, Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Adelbert B. Carter</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Tubbs</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>396-30-5069</u>		17. INFORMANT <u>Marjorie Hein</u>		Address <u>4805 Tallahassee Avenue</u> <u>Rockville, Maryland</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> <u>443x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>1-20</u> , 19 <u>66</u> , to <u>11-5</u> , 19 <u>65</u> that (I) (was) last saw the deceased alive on <u>11-5</u> , 19 <u>65</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>John C. K. Yu</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/2/66</u>					
22c. PHYSICIAN'S NAME (Type) <u>John C. K. Yu</u>				22d. ADDRESS <u>4912 Adrian St., Rockville, Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-5-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Anneton, Wisconsin</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>				ADDRESS <u>8434 Georgia Avenue</u> <u>Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 6 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

2300

3/2/8

1 *LD*
 00959
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH
 00937

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>	
c. LENGTH OF STAY IN 1b <i>2 yrs</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>407. Tulip Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>Elizabeth</i> First <i>Hendershot</i> Middle Last		4. DATE OF DEATH <i>Jan 6 1966</i> Month Day Year	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 11, 1911</i>
9. AGE (in years lost birthday) <i>54</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Manager</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles Emory Latta</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Elizabeth Hilder</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Eliz. L. Hendershot</i>	
17. INFORMANT <i>Eliz. L. Hendershot</i>		Address <i>407 Tulip Ave Takoma Park</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Esophageal Carcinoma - Epidermoid type</i> 150 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Metastases to lungs</i> DUE TO (c) <i>Tuberculous pneumonia</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Acute pneumonia same as above</i> INTERVAL BETWEEN ONSET AND DEATH <i>July 1965</i> <i>July 1965</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>8/22/1939</i> to <i>1/6/66</i> , that (I) (we) last saw the deceased alive on <i>1/5/66</i> , and that death occurred at <i>10:30 A.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Howard T. Morse</i> M.D.		22b. DATE SIGNED <i>1/6/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>Howard T. Morse</i>		22d. ADDRESS <i>MD 7030 Carroll Ave Takoma Park MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Jan. 10, 1966</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Rockville Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John Walters</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
ADDRESS <i>257 Carroll St NW DC</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

10055

CERTIFICATE OF DEATH

10055

231

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00960					00938						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY Montgomery					a. STATE Md. b. COUNTY District of Columbia Prince Georges						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (rural)					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington						
c. LENGTH OF STAY IN 1b 5 days					d. STREET ADDRESS 5204 Carriage Drive						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year		
Barbara Jane Hickey						January			30 19 66		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
Female		Caucasian		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Nov. 5, 1965		-- yrs. 2		Months 25 Days 25 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
								Andrews AFB, Md.		U.S.A.	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
Timothy A. Hickey						Ila Derrille Hill					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. N/A		17. INFIRMANT 5204 Carriage Drive Timothy A. Hickey, Washington, D.C.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital Heart Disease 7545 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (this hospital) attended the deceased from Jan. 25, 1966 to Jan. 30, 1966 , that (we) last saw the deceased alive on Jan. 30, 1966 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.											
22a. SIGNATURE J. I. Lynch						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Jan. 31, 1966			
22c. PHYSICIAN'S NAME (Type) J. I. Lynch						22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)			
BURIAL			2 FEB. 1966		PINECREST CEMETERY			MOBILE ALABAMA			
24. FUNERAL DIRECTOR Rinaldi F.H., Washington, D.C.						25a. REC'D BY REGISTRAR 20012		25b. REGISTRAR'S SIGNATURE Charles Judge			

5-179953

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Technical (General)

U. S. Naval Hospital

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Hospital

U. S. Naval Hospital

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U. S. Naval Hospital

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> c. LENGTH OF STAY IN 1b <i>6 yrs</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>9307 Walden Road,</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> d. STREET ADDRESS <i>9307 Walden Road</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Roy</i> Middle <i>Miller</i> Last <i>Hickman</i>		4. DATE OF DEATH Month <i>January</i> Day <i>8</i> Year <i>19 66</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 18, 1877</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired produce merchant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>self-employed</i>	9. AGE (In years last birthday) <i>88</i> yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Hickman</i>		14. MOTHER'S MAIDEN NAME <i>Mary Kalb</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>577-10-6464</i>	
17. INFORMANT <i>Mrs. Virginia B. Catlett</i>		Address <i>9307 Walden Road Silver Spring, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Thrombosis, Coronary</i> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <i>Atherosclerosis</i> 15 yrs.			INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1951</i> , 19 <i>51</i> to <i>Jan 8</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Jan 3</i> 19 <i>66</i> , and that death occurred at <i>12:55</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>A.W. Smith</i>		22b. DATE SIGNED <i>1-8-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>A.W. SMITH</i>		22d. ADDRESS <i>13018 GEORGIA AVE WHEATON, MD.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1-10-66</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Glenwood Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Washington, D. C.</i>	
24. FUNERAL DIRECTOR <i>Harper E. Humphrey, Inc.</i>		25a. REC'D BY REGISTRAR <i>JAN 13 1966</i>	
25b. REGISTRAR'S SIGNATURE <i>James E. Judge</i>			

14200

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

00962

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00940

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 4 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in only event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN 1b <u>DoA</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>11411 Rockville Pike</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Carroll</u> Middle <u>Montgomery</u> Last <u>Higgins</u>		4. DATE OF DEATH Month <u>JAN.</u> Day <u>22</u> Year <u>1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/8/1915</u>
9. AGE (In years lost birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>cab driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Trans.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Howard Higgins</u>		14. MOTHER'S MAIDEN NAME <u>Libbie Abbott</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Wife. Ada Higgins</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>451X</u> IMMEDIATE CAUSE (a) <u>Ruptured Abdominal Aortic Aneurysm</u> DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>1/22/66</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 25, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>		23d. LOCATION (City or Town) (County) (State) <u>Sunshine Mont. Md.</u>	
24. FUNERAL DIRECTOR <u>Francis H. Barber</u>		ADDRESS <u>Laytonsville, Md.</u>	
25a. REC'D BY REGISTRAR <u>JAN 25 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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John D. Hall

James D. Hall

James D. Hall

James D. Hall

James D. Hall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
00963 00941													
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN 1b <u>17 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. SAN. & Hosp.</u>						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montg.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK 15-1</u> d. STREET ADDRESS <u>8011 Flower Av.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY AMELIA HILGERS</u>						4. DATE OF DEATH Month Day Year <u>1 23 1966</u>							
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-11-75</u>		9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>GERMANY</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>GUSTAVE KINNER</u>						14. MOTHER'S MAIDEN NAME <u>PAULINE KELLER</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>HOSPITAL RECORDS.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200 Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Generalized atherosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												INTERVAL BETWEEN ONSET AND DEATH <u>Since 11-6-66</u> <u>Known since Jan 6, 1966</u> <u>Unknown</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Jan 6</u> , 19 <u>66</u> , to <u>Jan 23</u> , 19 <u>66</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Jan 23</u> , 19 <u>66</u> , and that death occurred at <u>1:50</u> M, from the causes and on the date stated above.													
22a. SIGNATURE <u>Aaron H. Traum</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>January 24 1966</u>					
22c. PHYSICIAN'S NAME (Type) <u>AARON H. TRAUM</u>						22d. ADDRESS <u>8237 Georgia Ave - Silver Spring Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Jan 25 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Luke's</u>				23d. LOCATION (City, town or county) (State) <u>Beltsville Md.</u>					
24. FUNERAL DIRECTOR <u>Arthur Waters</u>						25a. REC'D BY REGISTRAR <u>Jan 26 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

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FOR STATE
HEALTH DEPT

00964

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item #7 Film #G373 1/26/66 pc

00942

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 6 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LESLIE F HILL		4. DATE OF DEATH 1 12 19 66	
5. SEX m	6. COLOR OR RACE w	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/1/11 54
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) MASSACHUSETTS	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 451-01-6836	
		17. INFORMANT Hosp. Records Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive hemorrhage during pneumonectomy DUE TO (b) for Bronchogenic carcinoma, left lung. DUE TO (c) 1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap M.D.		22. DATE SIGNED JAN. 12, 1966	
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		23. NAME OF CEMETERY OR CREMATORY County Burial Ground	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 1/19/66	
23c. NAME OF CEMETERY OR CREMATORY County Burial Ground		23d. LOCATION (City or Town) (County) (State) Rockville, Montg., Maryland	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		25. REC'D BY REGISTRAR JAN 21 1966	
25a. ADDRESS 1391 Rockville Pike Rockville, Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00965						00943					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY <i>Montgomery</i>			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>			c. LENGTH OF STAY IN 1b <i>19 Months</i>			d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Kensington Gardens. 3000 McClellan</i>		
e. STATE <i>Maryland</i>			f. COUNTY <i>Montgomery</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase</i>			d. STREET ADDRESS <i>3705 - Williams Lane</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <i>ARTHUR W. HILTON</i>			4. DATE OF DEATH Month <i>January</i> Day <i>6</i> Year <i>1966</i>								
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>March 5, 1881</i>		9. AGE (In years last birthday) <i>84</i> yrs.		10. IF UNDER 1 YEAR Months <i>10</i> Days <i>1</i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Internal Revenue</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Clerk</i>				11. BIRTHPLACE (County & State, or foreign country) <i>Nova Scotia</i>			
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>				13. FATHER'S NAME <i>George Hilton</i>				14. MOTHER'S MAIDEN NAME <i>Lucinda Kelly</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>Unknown</i>				17. INFORMANT <i>Wife</i> <i>Mrs. Blanche C. Hilton</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i> DUE TO (b) <i>Cerebral Hemorrhage</i> DUE TO (c) <i>331X</i>				19. INTERVAL BETWEEN ONSET AND DEATH <i>13 hours</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerosis, Generalized</i>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>None</i>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>None</i> p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>			
20f. (City or town) (County) (State) <i>None</i>											
21. I certify that (I) (this hospital) attended the deceased from <i>October</i> , 19 <i>63</i> , to <i>January 6</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>January 6, 1966</i> , and that death occurred at <i>8:00 PM</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>James M. Loftus</i>								22b. DATE SIGNED <i>January 6, 1966</i>			
22c. PHYSICIAN'S NAME (Type) <i>JAMES M. LOFTUS</i>								22d. ADDRESS <i>5415 - Connecticut Ave. Wash.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>1-10-66</i>				23c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek Cemetery</i>			
23d. LOCATION (City, town or county) (State) <i>Washington, D. C.</i>				23e. REC'D BY REGISTRAR <i>Charles Judge</i>				23f. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY</i>				ADDRESS <i>Bethesda, Maryland</i>				DATE <i>JAN 10 1966</i>			

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STATE OF TEXAS

George Hilton
Mrs. Blanche C. Hilton
1924

1-10-26
Hobbs, Texas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
00966					CERTIFICATE OF DEATH					00944				
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5519 Glenwood Road					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 5519 Glenwood Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Carrie Lena Hitchcock					4. DATE OF DEATH Jan. 1, 1966									
5. SEX Female		6. COLOR OR RACE Cauc.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 20, 1883		9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Toronto, Canada			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Frederik William Daum					14. MOTHER'S MAIDEN NAME Rebecca Gault									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 578-28-5716		17. INFORMANT Ruth Hitchcock, Same as item #2			Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) THROMBOSIS, RIGHT MIDDLE CEREBRAL ARTERY 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO SCLEROSIS, GENERAL DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH 10 DAYS 10 YRS				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from FEB. 27, 1954 to JAN. 1, 1966 , that (I) (we) last saw the deceased alive on DEC. 31, 1965 , and that death occurred at 1:40 P.M. from the causes and on the date stated above.														
22a. SIGNATURE Robert G. Angle					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED JAN. 1, 1966							
22c. PHYSICIAN'S NAME (Type) Robert G. Angle					22d. ADDRESS 5009 Del Ray Ave, Bethesda, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/4/66		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery			23d. LOCATION (City, town or county) (State) Rockville Md.							
24. FUNERAL DIRECTOR Jos. Gawler's Sons, 5130 Wis. Ave, Wash.					ADDRESS		25a. REC'D BY REGISTRAR JAN 7 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge					

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FOR STATE
HEALTH DEPT.

00967

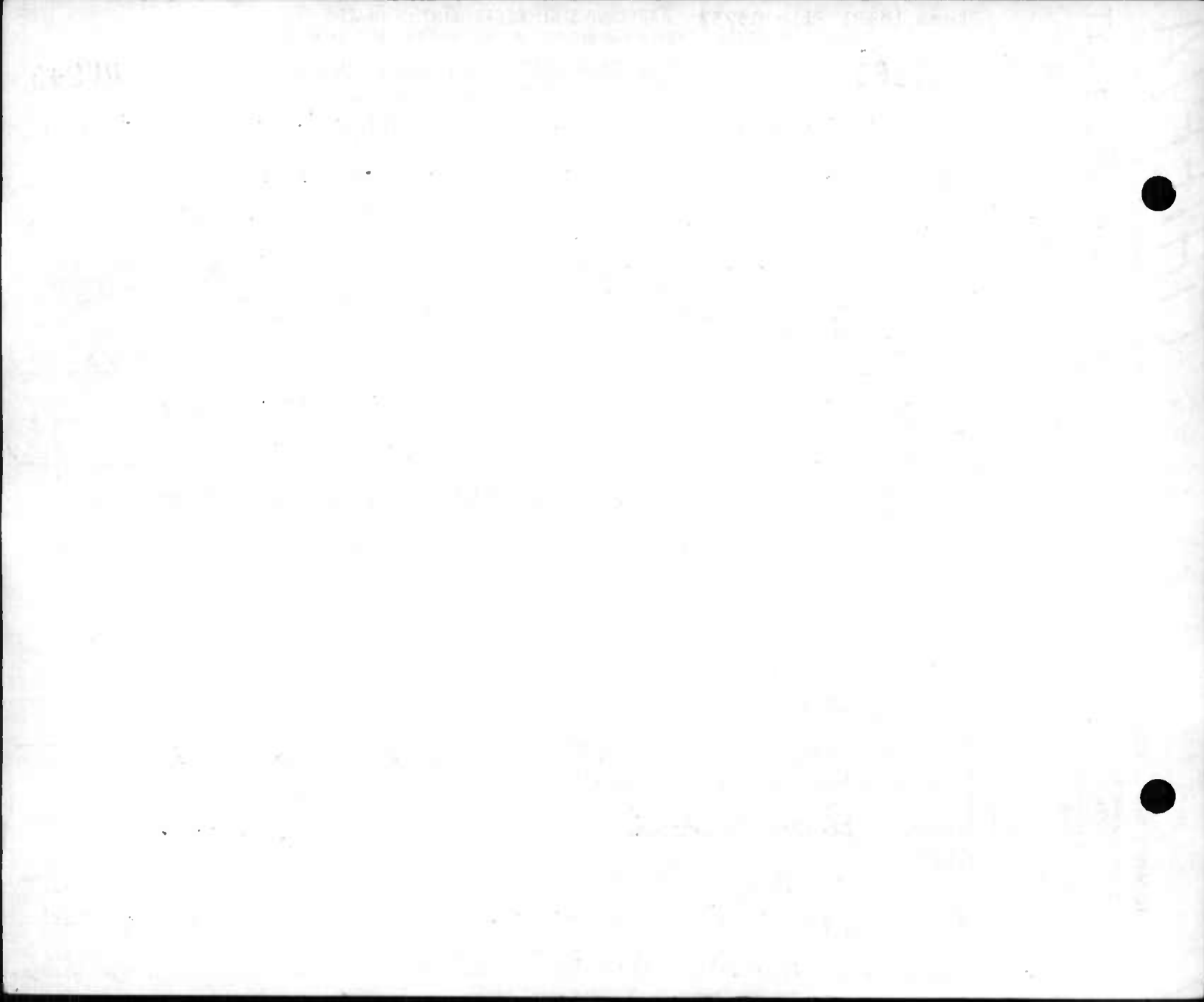
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00945

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington.</u>		c. LENGTH OF STAY IN 1b <u>1 year.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4007 Pleyers Mill Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clarence Edgar Hodge.</u>		4. DATE OF DEATH Month Day Year <u>Jan. 22 1966</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>Colored.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-15-1919</u>
9. AGE (In years lost birthday) <u>46</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Hodge</u>	
14. MOTHER'S MAIDEN NAME <u>Blanche Hopkins</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>yes WHITE</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Trobey Hodge (wife)</u> Address <u>Prince Frederick, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>5811</u> IMMEDIATE CAUSE (a) <u>Probable Acute fatty metamorphosis of liver</u> DUE TO (b) <u>Acute and chronic alcoholism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> Years
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John B. Ball.</u> M.D.		22. DATE SIGNED <u>1/23/66</u>	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Jan. 27, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial</u>	23d. LOCATION (City or Town) (County) (State) <u>Sandy Spring Md.</u>
24. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		25. REC'D BY REGISTRAR <u>Rockville, Md.</u>	
26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>FEB 1 1966</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00968 02482											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>- -</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>23-3</u> d. STREET ADDRESS <u>3837 Upland</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Elizabeth H. Hoge</u>						4. DATE OF DEATH <u>1 - 30 1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-22-'78</u>		9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR: Months <u>8</u> Days <u>2</u> Hours <u>15</u> Min.	
1da. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				1db. KIND OF BUSINESS OR INDUSTRY <u>- -</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Phillip B. Hiden</u>						14. MOTHER'S MAIDEN NAME <u>Betty H. Goodwin</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>				16. SOCIAL SECURITY NO. <u>577-40-1558</u>		17. INFORMANT <u>Hospital Records</u>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer Colon recurrent</u> 1530 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>marked anemia</u> DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
2Da. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
2Dc. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2Df. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>1/6/66</u> , 19 <u>66</u> , to <u>1/29/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1/29/66</u> , 19 <u>66</u> , and that death occurred at <u>5:30</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Chas H Wolotton</u>						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <u>Chas H Wolotton</u>						22d. ADDRESS <u>800 Pershing Dr. Silver Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>			23b. DATE THEREOF <u>2-3-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>			
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> <u>5130 Wisc. Ave. N.W. Wash. DC.</u>						25a. REC'D BY REGISTRAR <u>FEB 8 1966</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00969

00946

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 24 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Forestville 16-2	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.						e. STREET ADDRESS 4709 Allentown Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Julie Lynn Howell		First		Middle		Last		4. DATE OF DEATH Month January		Day 6	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 18 December 1961		9. AGE (In years last birthday) 4 yrs.		IF UNDER 1 YEAR Months 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Nebraska				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Robert G. Howell						14. MOTHER'S MAIDEN NAME Dolores Pruyne					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 7545 DUE TO postoperatively by clotted blood Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Occlusion of Prosthetic Mitral Valve / DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 2 days 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congenital Heart Disease 4 years											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that 10 (this hospital) attended the deceased from December 13, 1965 to January 6, 1966 , that 10 (we) last saw the deceased alive on January 6, 1966 , and that death occurred at 10:07 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Douglas M. Behrendt						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 6 January 1966			
22c. PHYSICIAN'S NAME (Type) Douglas M. Behrendt, M.D.						22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-10-66		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington Virginia		25a. REC'D BY REGISTRAR Charles Judge			
24. FUNERAL DIRECTOR Wilhelm Funeral Home 4308 Suitland Rd Suitland Maryland						25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JAN 11 1966			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

00970

00947

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indianhead 08-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2507 Henderson Ave.		d. STREET ADDRESS 5 Glymont Rd.	
3. NAME OF DECEASED (Type or print) Rosa Castelia Howell		4. DATE OF DEATH 1 23 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1-20-1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Charles Joseph Brewer		14. MOTHER'S MAIDEN NAME Virginia Campbell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Bertha E. Hightman		Address Wheaton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443x Acute Congestive Heart Failure DUE TO (b) Hypertensive Heart Disease DUE TO (c) Hypertensive Heart Disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap M.D.		22. DATE SIGNED Jan. 23, 1966	
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-26-1966	
23c. NAME OF CEMETERY OR CREMATORY Wash. D.C.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Robert A. Mattingly		ADDRESS 131-14 St. Wash. D.C.	
25a. REC'D BY REGISTRAR JAN 26 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

54771



TO DEPUTY MEDICAL EXAMINER: This certificate should be examined within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PW-6. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, not to burial, cremation, or removal, and if movement within 12 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH # 00948

00071

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residential Address) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Olney		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Spring Beltsville 16-2	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montgomery General Hospital		d. STREET ADDRESS 3110 Fairland Rd. 2801 Olney Spring Rd.	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
			Richard	Reginald	Hudson		1	16	19 66
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH			9. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8/18/65			vrs.	Months	Days	Hours Min.
								28	

9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME George A. Hudson	14. MOTHER'S MAIDEN NAME Mary ^A Anna Simmons
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
None	None	George Hudson	3410 Fairland Rd, Beltsville
		Hospital records and	on coronor Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Asphyxiation due to</u> 9210 DUE TO (b) <u>aspiration of gastric</u> DUE TO (c) <u>contents.</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

200. EXTERNAL CAUSE WAS
PRIMARY ☒ OF CONTRIBUTING ☐
CAUSE OF DEATH.

200. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
Deceased infant aspirated gastric

20c. TIME OF INJURY Month, Day, Year 8:00 a.m. 1-16 1966	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Sandy Spring Montgomery Md.
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21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Belden R. Reap, M.D. CHIEF MEDICAL EXAMINER ☐
 M.D. ASSISTANT MEDICAL EXAMINER ☐ 22. DATE SIGNED
 EXAMINER'S NAME (Type) Belden Reap, M.D. DEPUTY MEDICAL EXAMINER ☒ California
 Address (Street, City, Town, or County) JAN. 16, 1966

23a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>1-19-66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Calvert Cemetery</i>	23d. LOCATION (City, town or county) <i>Huntingtown, Maryland</i>	(State)
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24. FUNERAL DIRECTOR <i>Clark & Wilson</i>	ADDRESS <i>8434 Georgia Avenue Silver Spring, Md.</i>	25b. REC'D BY REGISTRAR DATE <i>JAN 24 1956</i>	25c. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN lb <u>22 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON SAN & Hosp</u>						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONT-</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10830 CHILDS ST. 15-1</u> d. STREET ADDRESS <u>SILVER SPRING</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>JOHN.</u> Middle <u>ROOKER</u> Last <u>JACKSON</u>						4. DATE OF DEATH Month <u>1</u> Day <u>25</u> Year <u>1966</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-4-12</u>		9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRESSROOM SUPER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>WASHINGTON POST.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>VA.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>WILLIAM A. Jackson</u>						14. MOTHER'S MAIDEN NAME <u>ELVA ROOKER</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>UNOBTAINABLE</u>		17. INFORMANT <u>Helen S. Jackson</u> Address <u>10830 Childs Street Silver Spring, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>465X</u> DUE TO <u>Pulmonary Embolism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 20, 1966</u> , to <u>Jan 25, 1966</u> , that (I) (we) last saw the deceased alive on <u>January 25, 1966</u> , and that death occurred at <u>9:30 A.M.</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Boris Rabkin</u>						22b. DATE SIGNED <u>Jan 25, 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>Boris Rabkin</u>			
22d. ADDRESS <u>1019 University Blvd. E., S. S., Md.</u>						22e. ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> STAFF DIRECTOR <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-29-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sherwood Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Salem, Virginia</u>			
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>						24a. ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 28 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00973

00950

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN 1b <u>24 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Potomac Valley Nursing Home</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Rockville Md.</u> b. COUNTY <u>MONTG.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>6902 Tildenwood Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Lena (Magdelene)</u> Middle <u>Jarman</u> Last <u>Jarman</u>			4. DATE OF DEATH Month <u>JAN.</u> Day <u>7</u> Year <u>1966</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 25, 1885</u>	9. AGE (In years last birthday) <u>80(?)</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>#</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>William Moyer</u>			14. MOTHER'S MAIDEN NAME <u>Ms ELLEN Lamb</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>483-10-6821</u>	17. INFORMANT <u>ELAINE MAUSER</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1961</u> , 19 to <u>Jan. 7</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>Jan. 6</u> 19 <u>66</u> and that death occurred at <u>10:24</u> M, from the causes and on the date stated above.					
22a. SIGNATURE <u>[Signature]</u>			22b. DATE SIGNED <u>1/7/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>Luciano I. Leal</u>			22d. ADDRESS <u>Guthersburg, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transit</u>		23b. DATE THEREOF <u>1/9/66</u>	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State) <u>Riverton, Iowa</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler - Rockville, Md.</u>			25a. REC'D BY REGISTRAR <u>JAN 12 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

MEDICAL CERTIFICATION

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CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH AND HUMAN SERVICES
FEDERAL BUREAU OF INVESTIGATION

1. Name of deceased: [illegible]
2. Date of death: [illegible]
3. Place of death: [illegible]
4. Cause of death: [illegible]
5. Manner of death: [illegible]
6. Signature of physician: [illegible]
7. Signature of medical examiner: [illegible]
8. Signature of coroner: [illegible]
9. Signature of registrar: [illegible]

10. Signature of [illegible]
11. Signature of [illegible]
12. Signature of [illegible]
13. Signature of [illegible]
14. Signature of [illegible]
15. Signature of [illegible]
16. Signature of [illegible]
17. Signature of [illegible]
18. Signature of [illegible]
19. Signature of [illegible]
20. Signature of [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
00974													
1. PLACE OF DEATH COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN lb 12/29/65-1/15/66 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kensington Gardens Sanitarium				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 4700 Kemper Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Joseph Jelicka		4. DATE OF DEATH Month January Day 16 Year 1966		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 28, 1887			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman-Norton Abrasive		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Gottlieb Jelicka				14. MOTHER'S MAIDEN NAME Louisa Treibler									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 017-09-8474				17. INFORMANT Roula Jelicka - Holyoke, Mass.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Emphysema 5020 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Bronchitis OUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												INTERVAL BETWEEN ONSET AND DEATH years years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)													
21. I certify that (I) (this hospital) attended the deceased from 3/27/65 to 1/16/66 , 19 66 that (I) (we) last saw the deceased alive on 1/16/66 19 66 and that death occurred at 1:15 PM from the causes and on the date stated above.													
22a. SIGNATURE John J. Curry 22b. DATE SIGNED 1/17/66 22c. PHYSICIAN'S NAME (Type) John J. Curry 22d. ADDRESS 10620 Georgia Ave, Md													
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 1/20/66		23c. NAME OF CEMETERY OR CREMATORY Sten Valley				23d. LOCATION (City, town or county) (State) Barre, Mass					
24. FUNERAL DIRECTOR Lyon Wheeler, Funeral Home 1331 Rockville Pike, Rockville, Md.				25a. REC'D BY REGISTRAR JAN 19 1966				25b. REGISTRAR'S SIGNATURE Charles Judge					

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[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "John J. Gentry" and "10000" are visible.]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

FOR STATE HEALTH DEPT

00975

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 8, 9 Film G376 4/26/66 mb
MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02489

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda S.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville 15-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>14207 Avery Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Logan H. Johnson</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>31</u> Year <u>1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1912-53</u> AGE (In years, months, days) <u>Aug 20 / 1897</u> <u>68</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>MOUNT ZION MARYLAND</u>	
13. FATHER'S NAME <u>Alec Brent</u>		14. MOTHER'S MAIDEN NAME <u>Ida Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Victor Hammond</u>		Address <u>Rockville 14207 Avery Rd</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> DUE TO (b) <u>Cardio Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2</u> years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John B. Bell</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>2/1/66</u>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/6/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park</u>		23d. LOCATION (City or town) (County) (State) <u>Rockville Monty Md.</u>	
24. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		25a. REC'D BY REGISTRAR <u>Feb 8 1966</u>	
ADDRESS <u>Rockville Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

22. DATE SIGNED

11619

11619



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY IN 1b <u>7 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Sanitarium</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>4909 56th Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>May</u> Last <u>Johnston</u>		4. DATE OF DEATH Month <u>January</u> Day <u>2</u> Year <u>1966</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 8 1877</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Arkansas</u>	
13. FATHER'S NAME <u>Hiram Pope</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-52-7200</u>		
17. INFORMANT <u>Ella Mae Beach</u>		Address <u>Same as #2 (Daughter)</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary of esophagus</u> 150X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/23</u> , 19 <u>65</u> , to <u>1/2</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1/2</u> , 19 <u>66</u> , and that death occurred at <u>2 AM</u> , from the causes and on the date stated above.				
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>1/2/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>F Kreuzburg</u>		22d. ADDRESS <u>7852 16th Ave Wash DC</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/4/66</u>	23c. NAME OF CEMETERY OR CREMATORIUM <u>George Washington</u>	23d. LOCATION (City, town or county) (State) <u>Hyattsville, Md.</u>	
24. FUNERAL DIRECTOR <u>Francis Gasch's Sons</u>		ADDRESS <u>Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR <u>ATN 5</u> 1966
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

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Handwritten notes and stamps, including a date stamp "JAN 19 1964" and a reference number "100-100000".

Handwritten notes and stamps, including a date stamp "JAN 19 1964" and a reference number "100-100000".

Handwritten notes and stamps, including a date stamp "JAN 19 1964" and a reference number "100-100000".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> c. LENGTH OF STAY IN 1b <i>D. O. A.</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Holy Cross Hospital</i>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> <i>15-1</i> d. STREET ADDRESS <i>9406 Crosby Road</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <i>Bernard</i> Middle <i>Samuel</i> Last <i>Judd</i>			4. DATE OF DEATH Month <i>January</i> Day <i>24</i> Year <i>19 66</i>						
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 15, 1886</i>		9. AGE (In years last birthday) <i>79</i> yrs. IF UNDER 1 YEAR: Months <i>79</i> Days <i>79</i> Hours <i>79</i> Min. <i>79</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Pharmacist Retired</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Druggist</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Washington, D. C.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Theodore Judd</i>					14. MOTHER'S MAIDEN NAME <i>Elizabeth Almond</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give war or dates of service) <i>None</i>			16. SOCIAL SECURITY NO. <i>577-03-6839</i>		17. INFORMANT <i>Virginia W. Judd</i> Address <i>9406 Crosby Road Silver Spring, Maryland</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4201 CORONARY THROMBOSIS</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>CORONARY ARTERIO SCLEROSIS</i> (c) <i>DUE TO</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>RHEUMATIC HEART DISEASE</i>								INTERVAL BETWEEN ONSET AND DEATH <i>30 MIN</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>1959</i> to <i>1/24, 1966</i> , that (I) (we) last saw the deceased alive on <i>9/24 1964</i> , and that death occurred at <i>8:15 PM</i> , from the causes and on the date stated above.									
22a. SIGNATURE <i>[Signature]</i>					ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>1/24/66</i>		
22c. PHYSICIAN'S NAME (Type) <i>H. W. STOUT MD</i>					22d. ADDRESS <i>10211 GEORGETTA AVE SILVER SPRING MD</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>1-27-66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Washington D. C.</i>		
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i> ADDRESS <i>8434 Georgia Avenue Silver Spring, Md.</i>					25a. REC'D BY REGISTRAR <i>[Signature]</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL EXAMINER'S NOTICE: Any Has. A. APPROVED. Box

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00978 CERTIFICATE OF DEATH 00954									
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b 28/1446 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Holy Cross Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 9413 Biltmore Dr. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Lois First Middle Karasinski					4. DATE OF DEATH Month Jan. Day 16 Year 66				
5. SEX Female		6. COLOR OR RACE Cauc.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-29-1904		9. AGE (In years last birthday) 61 IF UNDER 1 YEAR: Months 8 Days 19 Hours 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (County & State, or foreign country) Norway, Iowa		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Friis					14. MOTHER'S MAIDEN NAME Etta Mabel Pirie				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 579-32-8578		17. INFORMANT Leon Karasinski		Address 9413 Biltmore Dr. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus								INTERVAL BETWEEN ONSET AND DEATH Immediate	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from Mar , 19 55 , to Jan 16 , 19 66 , that (I) (we) last saw the deceased alive on Dec , 19 65 , and that death occurred at 3:44 AM, from the causes and on the date stated above.									
22a. SIGNATURE Bernard A. Fitzgerald					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-16-66		
22c. PHYSICIAN'S NAME (Type) BERNARD A. FITZGERALD					22d. ADDRESS 217 UNIV. BLVD E, S.S., Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-20-66		23c. NAME OF CEMETERY OR CREMATORY Cedar Memorial Cemetery		23d. LOCATION (City, town or county) Cedar Rapids, Iowa (State) _____			
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.		ADDRESS 8434 Georgia Avenue Silver Spring, Md.		25a. REC'D BY REGISTRAR Jan 24 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

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[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "Norway" and "London" are faintly visible.]

[Vertical text on the right margin, possibly a date or reference number.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

00979

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00955

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 6209 Redwing Court	
3. NAME OF DECEASED (Type or print) Paula		First Jean		Middle Kasdon	
4. DATE OF DEATH January 1		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 9 August 1964		9. AGE (in years last birthday) 1 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.	
13. FATHER'S NAME Lawrence I. Kasdon		14. MOTHER'S MAIDEN NAME Charlotte Goldenberg		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Records The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Transposition of the great vessels, atresia 7547 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO (b) Postoperative right sided Blalock Shunt OUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				INTERVAL BETWEEN ONSET AND DEATH 16 months 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (this hospital) attended the deceased from Dec. 31, 1965, to Jan. 1, 1966, that (we) last saw the deceased alive on January 1, 1966, and that death occurred at 925 M, from the causes and on the date stated above.					
22a. SIGNATURE x [Signature]		22b. DATE SIGNED Jan. 1, 1966		22c. PHYSICIAN'S NAME (Type) Scott Stewart, M.D.	
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.		22e. REC'D BY REGISTRAR 22f. REGISTRAR'S SIGNATURE [Signature]			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 3, 1966		23c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden	
23d. LOCATION (City, town or county) Falls Church, Va.		23e. LOCATION (City, town or county) Falls Church, Va.			
24. FUNERAL DIRECTOR [Signature]		24a. ADDRESS [Address]			
24b. REC'D BY REGISTRAR JAN 4 1966		24c. REGISTRAR'S SIGNATURE [Signature]			

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STATE OF NEW YORK

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IN SENATE,
January 1, 1900.
REPORT
OF THE
COMMISSIONER OF THE LAND OFFICE,
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1899.
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J. B. LEECH, STATE PRINTER,
1899.

ALBANY:
J. B. LEECH, STATE PRINTER,
1899.

Items 18&21 Film G374 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) STATE <u>MD</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>733 Sligo Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Bernard</u> Middle <u>William</u> Last <u>Keating</u>		4. DATE OF DEATH Month <u>1</u> Day <u>27</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/15/97</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Kear's Dept. Store</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Bernard A. Keating</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Bledsoe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-03-4403</u>	
17. INFORMANT <u>Mr. Dorothy Keating (wife)</u>		Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intra - abdominal hemorrhage secondary</u>			
DUE TO <u>451X</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>to repair of abdominal aortic aneurysm.</u>			
DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u></u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-29-66</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>	
23. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		24a. REC'D BY REGISTRAR <u></u> 24b. REGISTRAR'S SIGNATURE <u></u>	
ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		DATE <u>FEB 1 1966</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 3 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL EXAMINER'S REPORT

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James A. Kesting

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Jan 21 1966

James A. Kesting

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared Per Dr. Keel

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>641 Silver Spgs.</u> d. STREET ADDRESS <u>641 Silver Ave</u> 15-18 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Rae</u> First Middle Last 4. DATE OF DEATH <u>Jan 18 1966</u> Month Day Year				5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>4-26-89</u> 9. AGE (In years last birthday) <u>26</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>578-36-2840</u> 17. INFORMANT <u>Julius W. Keel</u> Address <u>SSA 641 SILVER AVE</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200 Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Heart disease</u> DUE TO (c) <u>Many years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia</u>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 19</u> , 19 <u>66</u> , to <u>Jan 18</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Jan 18</u> , 19 <u>66</u> , and that death occurred at <u>11:20 AM</u> , from the causes and on the date stated above.															
22a. SIGNATURE <u>Sidney J. Cohen, M.D.</u>				22b. DATE SIGNED <u>Jan 19, 1966</u>				22c. PHYSICIAN'S NAME (Type) <u>Sidney J. Cohen, M.D.</u>				22d. ADDRESS <u>50 W. 6th Street, Rockville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>1-20-66</u>				23c. NAME OF CEMETERY OR CREMATORY <u>DC LODGE CEM</u>				23d. LOCATION (City, town or county) (State) <u>WASH. DC</u>			
24. FUNERAL DIRECTOR <u>GOLDBERG FUNERAL HOME</u>				ADDRESS <u>4217 9TH ST. N.W.</u>				25a. REC'D BY REGISTRAR <u>Jan 20 1966</u>				25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared by Dr. Kenton

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>11 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> d. STREET ADDRESS <u>1108 Midvale</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Levi H. King</u>			4. DATE OF DEATH Month <u>January</u> Day <u>26</u> Year <u>1966</u>										
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 30, 1896</u>		9. AGE (In years last birthday) <u>69 yrs.</u> Months <u>3</u> Days <u>11</u> Hours <u></u> Min. <u></u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>YARD Foreman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber Co.</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>					
13. FATHER'S NAME <u>Robert H. King</u>					14. MOTHER'S MAIDEN NAME <u>Minnie Moore</u>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>					16. SOCIAL SECURITY NO. <u>219-12-4239</u>		17. INFORMANT <u>Hampton F. King</u>					Address <u>901 Brice Rd. Rockville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic bronchitis and emphysema</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>1/15</u> , 19 <u>66</u> , to <u>1/26</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1/25</u> , 19 <u>66</u> , and that death occurred at <u>12:50 PM</u> from the causes and on the date stated above.													
22a. SIGNATURE <u>George S. Kenton</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/26/66</u>					
22c. PHYSICIAN'S NAME (Type) <u>George Kenton, M.D.</u>						22d. ADDRESS <u>10829 Georgia Ave., Wheaton, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>1/30/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Chestnut Grove Cem.</u>			23d. LOCATION (City, town or county) (State) <u>Herndon, Virginia</u>					
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>						Address <u>Bethesda, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00983				Items 14, 15 Film G374 3/27/66 mh				00959			
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 63 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Landisville c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Landisville d. STREET ADDRESS 50 Naomi Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Robert Middle John Last KING			4. DATE OF DEATH Month January Day 7 Year 19 66			5. SEX Male			6. COLOR OR RACE Cauc.		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH May 26, 1926			9. AGE (In years last birthday) 39 yrs.			IF UNDER 1 YEAR Months 3 Days 7 Hours 19 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) New York, New York			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME John King				14. MOTHER'S MAIDEN NAME Frances Radcliff			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) Yes WWII & Korea				16. SOCIAL SECURITY NO. 128 14 9973				17. INFORMANT Mrs. M. Virginia King			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphoma, malignant 2002 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)				20h. (City or town) (County) (State)			
21. I certify that the (this hospital) attended the deceased from Nov. 5, 1965 to Jan. 7, 1966 , that the (we) last saw the deceased alive on Jan. 7, 1966 , and that death occurred at 1020 AM , from the causes and on the date stated above.											
22a. SIGNATURE Francis C. Johnson						22b. DATE SIGNED Jan. 8, 1966			22c. PHYSICIAN'S NAME (Type) Francis C. Johnson		
22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.						22e. ADDRESS			22f. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 1-12-66				23c. NAME OF CEMETERY OR CREMATORY Arlington National			
23d. LOCATION (City, town or county) (State) Arlington, Virginia				23e. LOCATION (City, town or county) (State) Arlington, Virginia				23f. LOCATION (City, town or county) (State) Arlington, Virginia			
24. FUNERAL DIRECTOR R. A. Humphrey				24a. REC'D BY REGISTRAR JAN 11 1966				24b. REGISTRAR'S SIGNATURE J. Charles Judge			
24c. ADDRESS Funeral Home 7557 Wisconsin Ave. Bethesda, Md.				24d. ADDRESS				24e. ADDRESS			

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New York, New York

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James C. Thompson

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FOR STATE
HEALTH DEPT

MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00984

00960

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>6 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>University Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u> d. STREET ADDRESS <u>01-2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Francis Snyder Kinnison</u> First Middle Last		4. DATE OF DEATH <u>Jan. 15 1966</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>4/27/1873</u> 9. AGE (In years last birthday) <u>92</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Veterinarian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Animal Husb.</u>	11. BIRTHPLACE (State or foreign country) <u>Penna.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Joseph Kinnison</u>	
14. MOTHER'S MAIDEN NAME <u>Isadora Snyder</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Paul D. Eddy</u> Address <u>364 Stewart Ave. Garden City, L. I., N. Y.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO (b) <u>Arteriosclerotic Heart Disease</u> OUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap, M.D.</u> EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		22. DATE SIGNED <u>JAN, 16, 1966</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>Jan. 17, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>	23d. LOCATION (City, town or county) (State) <u>Prince Georges Co. Maryland</u>
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u> Address <u>8434 Georgia Ave. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 26 1966</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00224

STATE OF TEXAS
COUNTY OF DALLAS

1. Name of deceased: *John Doe*
2. Sex: *Male*
3. Age: *45*
4. Date of death: *10/15/1914*
5. Place of death: *Home*
6. Cause of death: *Heart disease*
7. Manner of death: *Natural*

8. Signature of medical examiner: *[Signature]*
9. Date of examination: *10/15/1914*
10. Signature of physician: *[Signature]*
11. Date of death: *10/15/1914*

12. Signature of registrar: *[Signature]*
13. Date of registration: *10/15/1914*
14. Signature of undertaker: *[Signature]*
15. Date of burial: *10/16/1914*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

Med. Cert. with At Death 1-18-66

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b D. O. A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington San. & Hospital					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 119 Melbourne Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Alice Frances Kinsey			4. DATE OF DEATH Jan. 18		5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		
8. DATE OF BIRTH March 2, 1913			9. AGE (In years last birthday) 52 yrs.		10. UNDER 1 YEAR Months Days		11. UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Manager			10b. KIND OF BUSINESS OR INDUSTRY Public Relations			11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Frank M. Lanham			14. MOTHER'S MAIDEN NAME Mary E. Fowler			15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 441 28 8907		
17. INFORMANT Jean Hollis			18. ADDRESS 7121 Poplar Ave. T. P. Md.			19. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			20. SOCIAL SECURITY NO. 441 28 8907		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized carcinomatosis 170X DUE TO (b) Mammary Carcinoma DUE TO (c) 55 mos. INTERVAL BETWEEN ONSET AND DEATH 7 mos.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
22a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			22b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		22c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		22d. (City or town) (County) (State)		22e. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21. I certify that (I) (this hospital) attended the deceased from 1/10, 1965 to 1/18, 1966 , that (I) (we) last saw the deceased alive on 1/18, 1966 , and that death occurred at 1:45 PM , from the causes and on the date stated above.											
22a. SIGNATURE Harry N. Carlton			22b. DATE SIGNED Jan 18, 1966			22c. PHYSICIAN'S NAME (Type) HARRY N. CARLTON			22d. ADDRESS 940-25th St, N.W. WASH. D.C.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 1-20-66		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town or county) (State) Washington, D. C.		23e. REC'D BY REGISTRAR JAN 24 1966		
24. FUNERAL DIRECTOR Harner E. Pumphrey, Inc.			24b. ADDRESS 8434 Georgia Avenue Silver Spring, Md.			24c. REGISTRAR'S SIGNATURE Johnas Judge		24d. DATE JAN 24 1966		24e. REGISTRAR'S SIGNATURE Johnas Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00987

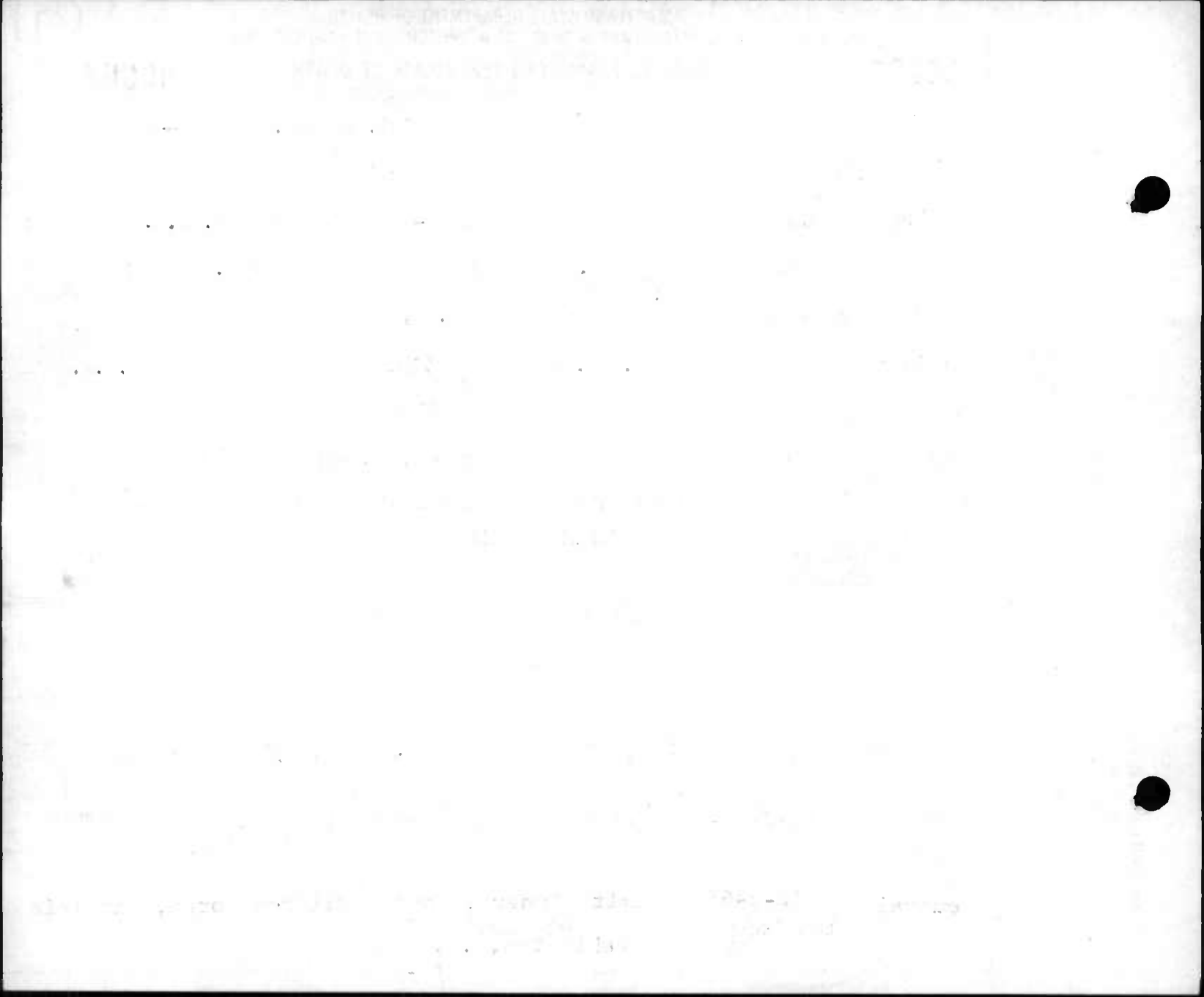
00962

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Dist. of Col. b. COUNTY ----			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 47-3		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Columbia Country Club				d. STREET ADDRESS 1227- Constitution Ave. N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Everett		First H. Middle Lacey Last		4. DATE OF DEATH Jan.		Month 2 Day 19 Year 66	
5. SEX Male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 9, 1902		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waiter		10b. KIND OF BUSINESS OR INDUSTRY Col. Co. Club		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Lacey				14. MOTHER'S MAIDEN NAME AltaMae			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Everett Morris Lacey/ Son Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5811 IMMEDIATE CAUSE (a) Acute fatty metamorphosis of Liver DUE TO Chronic alcoholism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John B. Bell		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 1/3/66	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 12-5-66		23c. NAME OF CEMETERY OR CREMATORY Smith Funeral Home		23d. LOCATION (City or Town) (County) (State) Clifton Forge, Virginia	
24. FUNERAL DIRECTOR Alex Pope		ADDRESS 414 15th SE Washington, D.C.		25a. REC'D BY REGISTRAR Jan 7 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

00986

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02493

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BELTSVILLE</u>	
c. LENGTH OF STAY IN 1b <u>24 day</u>		d. STREET ADDRESS <u>4516 Elmwood Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ANN ELIZABETH</u>		4. DATE OF DEATH <u>1 26 19 66</u>	
First Middle Last		Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>CAU</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/30/65</u>
9. AGE (In years last birthday) <u>1</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) <u>MONTGOMERY County MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>KOTULA, ANTHONY</u>		14. MOTHER'S MAIDEN NAME <u>Joan R. Rygielwicz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Anthony W. Kotula Beltsville Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>7511</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Meningocele</u> DUE TO (c) <u>multiple vertebral defects</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u> <u>27 days</u> <u>27 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-30, 19 65</u> to <u>1-26, 19 66</u> , that (I) (we) last saw the deceased alive on <u>1-26 19 66</u> , and that death occurred at <u>2:55 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Mary K. Sartwell</u>		22b. DATE SIGNED <u>1-26-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>MARY K SARTWELL</u>		22d. ADDRESS <u>6118 Reggs Rd Hyattsville Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/28/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		23d. LOCATION (City, town or county) (State) <u>Beltsville Md</u>	
24. FUNERAL DIRECTOR <u>F. Guschinski Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE	

5-147941

05130

RECEIVED OF 05130

05130

WILLIAM A. BROWN

3-13
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00988 CERTIFICATE OF DEATH 00963

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>75 days</u>	
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		15 -	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>3507 Leland St</u>	
3. NAME OF DECEASED (Type or print) <u>GEORGE Gernen LAHR</u>		4. DATE OF DEATH <u>Jan. 26 1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/29/92</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chem Eng</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Hudson New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Peter Baker</u>		14. MOTHER'S MAIDEN NAME <u>Meisen Becker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>146-093799</u>	
17. INFIRMANT <u>KATHLEEN</u> Address <u>Same as above</u>		18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ADENOCARCINOMA Prostate</u> <u>177X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>c wide spread metastases</u> (c) <u>5 1/2 years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis - severe.</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>February</u> , 19 <u>60</u> , to <u>January 26</u> , 19 <u>66</u> , that (I) was last saw the deceased alive on <u>1/25</u> , 19 <u>66</u> , and that death occurred at <u>1:55 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>J. Blaine Fitzgerald</u>		22b. DATE SIGNED <u>1/27/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>8218 Wisconsin Ave. Bethesda</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/31/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Park</u>		23d. LOCATION (City, town or county) (State) <u>Hudson N. York</u>	
24. FUNERAL DIRECTOR <u>Jos. Lawler's Sons Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>5130 2nd Ave. N.W.</u>		25b. REGISTRAR'S SIGNATURE	
DATE <u>FEB 3 1966</u>			

STATE OF NEW YORK

1900

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> d. STREET ADDRESS <u>10 George Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>W.</u> Last <u>Leigh</u>		4. DATE OF DEATH Month <u>January</u> Day <u>25</u> , Year <u>1966</u>									
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/17/91</u>								
9. AGE (In years last birthday) <u>75</u> yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		Hours		Min.	10. BIRTHPLACE (County & State, or foreign country) <u>R.R. New York</u> 11. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.										
Months	Days										
	Hours										
	Min.										
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Capt. tugboat-Erie</u>									
13. FATHER'S NAME <u>Eugene Lynes Leigh</u>		14. MOTHER'S MAIDEN NAME <u>Minnie H. Whitaker Whitcomb</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>706-12-2379</u>									
17. INFIRMANT (Daughter) <u>Evelyn L. Aderhold</u> Address <u>4714 Listra Rd. Rockville Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Melanotic adenocarcinoma</u> <u>15-38</u> DUE TO (b) <u>adenocarcinoma colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from <u>1-7</u> , 19 <u>66</u> , to <u>1-25</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1-24</u> , 19 <u>66</u> , and that death occurred at <u>8:45 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Donald L. Bucy MD</u>		22b. DATE SIGNED <u>1-27-66</u>									
22c. PHYSICIAN'S NAME (Type) <u>DONALD L. BUCY MD</u>		22d. ADDRESS <u>809 VEIR'S MILL RD ROCKVILLE, MD</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>1/29/66</u>									
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City, town or county) (State) <u>Prince George Co., Md.</u>									
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u> ADDRESS <u>1351 Rockville Pike Rockville, Maryland</u>		25a. REC'D BY REGISTRAR <u>FEB 1 1966</u>									
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME (5)
SM 1/65

<div>Items 18-21 Film 376 5-3-66</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>00990 00965</div>										
1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 25 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG, RURAL 15-1 d. STREET ADDRESS ROUTE #1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First ELI		Middle MOLESWORTH		Last LEISHEAR		4. DATE OF DEATH Month JANUARY Day 19 Year 1966		
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 2, 1891		9. AGE (In years last birthday) 74 yrs. IF UNDER 1 YEAR: Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME THOMAS M. LEISHEAR					14. MOTHER'S MAIDEN NAME MARY F. MOLESWORTH					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) --				16. SOCIAL SECURITY NO. --		17. INFORMANT MEDICAL RECORDS		Address OLNEY, MARYLAND		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary embolus secondary 904.0 DUE TO to fracture of left hip Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased, drinking at home, fell and fractured left hip.							
20c. TIME OF INJURY Month, Day, Year Hour 800 am 12-24 1965 p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Gaithersburg Montg. Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>Belden R. Reap</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) HEATON, MD.							
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.			22. DATE SIGNED Jan. 20, 1966							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Jan. 22, 1966		23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel		23d. LOCATION (City, town or county) (State) Sunshine, Md.			
24. FUNERAL DIRECTOR ADDRESS Olin L. Molesworth, Damascus, Md.						25a. REC'D BY REGISTRAR JAN 24 1966		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 7 Hours	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 1300 XAVERIA DR.	
3. NAME OF DECEASED (Type or print) First JACOB Middle B. Last LEVIN		4. DATE OF DEATH Month JAN. Day 5 Year 1966	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-18-1895 9. AGE (In years last birthday) 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER & PRINTER PAINTING		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME ISODORE HERMAN LEVIN		14. MOTHER'S MAIDEN NAME Rose-----	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. -	
17. INFORMANT SON		Address ISODORE H. LEVIN 1300 XAVERIA DR.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5411 Deinfarmitis DUE TO Perforated Duodenal Ulcer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 18 hrs. DUE TO (c) 18 hrs.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-5 , 19 66 , to 1-5 , 19 66 , that (I) (we) last saw the deceased alive on 1-5 19 66 and that death occurred at 6:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Richard L. Cohen		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 1-6-66
22c. PHYSICIAN'S NAME (Type) Richard L. Cohen, M.D.		22d. ADDRESS 800 Pershing Drive, Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/6/66	23c. NAME OF CEMETERY OR CREMATORY Nat. Cap. Hebrew Cem.	23d. LOCATION (City, town or county) (State) Washington, D. C.
24. FUNERAL DIRECTOR Bernard Danzansky & Sons 3501 14th St., N. W., Wash., D. C.		25a. REC'D BY REGISTRAR JAN 10 1966 25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Germantown</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Marylander Home of Rest</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Dist. of Col.</u> b. COUNTY <u>-</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>3204 Porter St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emily</u> Middle <u>May</u> Last <u>Libbey</u>		4. DATE OF DEATH Month <u>1</u> Day <u>19</u> Year <u>1966</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>6-15-1880</u>		9. AGE (In years last birthday) <u>85</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Director (Education)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private School</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Libbey</u>		14. MOTHER'S MAIDEN NAME <u>Emma Valiant</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>- - -</u>	
17. INFORMANT <u>Mr. Bainbridge Crist, (Nephew)</u>		<u>4908 Jamestown Road, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular collapse</u> DUE TO (b) <u>Gastric obstruction</u> DUE TO (c) <u>Gastrointestinal tumor - probable</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>None</u> e.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1961, 19</u> to <u>present</u> , that (I) (we) last saw the deceased alive on <u>1/18, 1966</u> , and that death occurred <u>1/19</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>John B. Umhau</u> M.D.		22b. DATE SIGNED <u>1/19/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN B. UMHAU MD</u>		22d. ADDRESS <u>8805 Can. Ave. Ph. Ch. Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>1-21-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City, town or county) (State) <u>Suitland, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gawler's Sons, Inc.</u> ADDRESS <u>5130 Wisconsin Ave. N.W. Wash. DC.</u>		25a. REC'D BY REGISTRAR <u>JAN 26 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>William J. Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
00993					00968					
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN ID <u>15 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1218 Dale Drive</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1218 Dale Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Nathan</u> First <u>(nmr)</u> Middle <u>Louft</u> Last			4. DATE OF DEATH Month <u>January</u> Day <u>3</u> Year <u>19 66</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 20, 1901</u>		9. AGE (in years last birthday) <u>64</u> yrs. IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Printing</u>			11. BIRTHPLACE (County & State, or foreign country) <u>St. Petersburg, Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry A. Louft</u>					14. MOTHER'S MAIDEN NAME <u>Sarah Strurinsky</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>578-46-8105</u>		17. INFORMANT <u>Rosemary E. Louft</u>		Address <u>1218 Dale Drive Silver Spring, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of stomach</u> 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>widespread metastases</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> , 19 <u></u> , to <u>Jan 3</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3 Jan</u> 19 <u>66</u> , and that death occurred at <u>12:11 M.</u> from the causes and on the date stated above.										
22a. SIGNATURE <u>Ernest E. Hummon</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED <u>3 Jan 66</u>					
22c. PHYSICIAN'S NAME (Type) <u>Ernest E. Hummon</u>					22d. ADDRESS <u>9301 Colesville Rd Silver Spring</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>1-5-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Port Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges Co. Maryland</u>			
24. FUNERAL DIRECTOR <u>Glenn Carter</u> <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>					25a. REC'D BY REGISTRAR <u>Jan 7 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY in 1b <u>47 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>15-1</u> d. STREET ADDRESS <u>12834 L. Hutton St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edgar</u> Middle <u>Corey</u> Last <u>Lowe</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>1</u> Year <u>1966</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/14/96</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Interior Decorator</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Richmond Va.</u>			
13. FATHER'S NAME <u>George Lowe</u>		12. CITIZEN OF WHAT COUNTRY?					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>519-30-7438</u>		17. INFORMANT <u>Mrs. E. K. Lowe</u> Address <u>12834 L. Hutton St. Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recent Thrombosis of r.t. coronary artery</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bullous pulmonary edema</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>12-30-1965</u> to <u>1-1-1966</u> , that (I) <u>two</u> last saw the deceased alive on <u>1-1-1966</u> , and that death occurred at <u>2:25</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>JASON GERGER, M.D.</u>				22b. DATE SIGNED <u>1-2-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>JASON GERGER, M.D.</u>				22d. ADDRESS <u>800 Kensington Drive Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>JAN-4-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Eden Hill of Loudoun Rd. Md.</u>			
23d. LOCATION (City, town or county) (State)							
24. FUNERAL DIRECTOR <u>Edna Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
25c. ADDRESS <u>254 Carroll St. Silver Spring, Md.</u>		DATE <u>JAN 4 1966</u>					

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN b. <u>15-1</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> #3 <u>Books Hill Rd. Apt. #810</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Rita N. Lowell</u>			4. DATE OF DEATH Month <u>1</u> Day <u>23</u> Year <u>1966</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/8/1888</u>	9. AGE (In years last birthday) <u>77</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Roger Neighbours</u>			14. MOTHER'S MAIDEN NAME <u>Ann Beenneman</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>	17. INFORMANT <u>Husband - John D. Lowe</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GASTRO-ENTERITIS</u> DUE TO (c) <u>CARCINOMA OF BOWEL</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>4 DAYS</u> <u>3 YRS</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE, 1963</u> , to <u>JAN, 1966</u> , that (I) (we) last saw the deceased alive on <u>JAN 22</u> 19 <u>66</u> , and that death occurred at <u>2:4</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u> M.D.				22b. DATE SIGNED <u>1/23/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>DR. LEO J. DENOVAN</u>				22d. ADDRESS <u>8215 WISC. AVE BETHESDA 14 MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1-25-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	23d. LOCATION (City or Town) <u>Prince Georges Co.</u> (County) <u>MD.</u> (State)				
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>			25a. REC'D BY REGISTRAR <u>JAN 26 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10/1/41

RECEIVED

10/1/41

10/1/41

10/1/41



Certificate signed & concurrence of Medical Examiner.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00996

CERTIFICATE OF DEATH

00971

Item #9 Film #G313 2/13/66 pg

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK c. LENGTH OF STAY IN 1b 70 1/2 hrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON SAN & Hosp			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE WASH DC b. COUNTY Pinkney c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASH. DC. 16-2 d. STREET ADDRESS 7404 OXEN HILL RD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First JOHN Middle ROSCOE Last LUDHAM			4. DATE OF DEATH Month 1 Day 25 Year 1966		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-3-01	9. AGE (In years last birthday) 65 1/2 yrs.	IF UNDER 1 YEAR Months 6 Days 21 Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY FIRE DPT.		11. BIRTHPLACE (County & State, or foreign country) MARYLAND	
13. FATHER'S NAME JOHN LUDHAM			14. MOTHER'S MAIDEN NAME NOT KNOWN		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT PTS CHART Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic & Hypertensive Cardiovascular Dis. 3 yrs. DUE TO (c) Arteriosclerosis Generalized 10 yrs.				INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity, G.I. Hemorrhage, Severe Anemia, Likely Ulcer, Probable Diabetes of Duodenum					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from January 21, 1966 , to Jan- 25, 1966 , that (I) was last saw the deceased alive on January 24, 1966 , and that death occurred at 1:15 A.M. from the causes and on the date stated above.					
22a. SIGNATURE Walcott W. Gibson		M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED January 25, 1966	
22c. PHYSICIAN'S NAME (Type) Walcott W. Gibson, M.D		22d. ADDRESS 4300 St. Barnabas Road, (via D.C. 20031)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 1-26-1966		23c. NAME OF CEMETERY OR CREMATORY Wash. D.C.	
23d. LOCATION (City, town or county)		(State)			
24. FUNERAL DIRECTOR Walters		ADDRESS 131-11th St. S.E. D.C.		25a. REC'D BY REGISTRAR 28 1966	
25b. REGISTRAR'S SIGNATURE James Judge					

1880

RECEIVED

1880

[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00997 Item #7 Film #8373 2/10/66											
00972											
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Montgomery</i>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>				c. LENGTH OF STAY IN 1b <i>2 + mths</i>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Wheaton Nursing Home</i>				d. STREET ADDRESS <i>10820 Ga. Avenue</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>NELLIE</i> Middle <i>R.</i> Last <i>MACFARLANE</i>				4. DATE OF DEATH Month <i>Jan.</i> Day <i>27</i> Year <i>1966</i>							
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9/16/1878</i>		9. AGE (in years last birthday) <i>87</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>clerk - Government</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Federal Government</i>				11. BIRTHPLACE (County & State, or foreign country) <i>Kent Co. Delaware</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William R. MacFarlane</i>				14. MOTHER'S MAIDEN NAME <i>Caroline Cooper</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Nursing Home Records</i>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> 332x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized arteriosclerosis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <i>1 wk.</i> <i>years.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from <i>July 1, 1960</i> , to <i>Jan 26, 1966</i> , that (1) (we) last saw the deceased alive on <i>Jan 26, 1966</i> , and that death occurred at <i>4:30 AM</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>James R. Coleman MD.</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <i>1/27/66.</i>			
22c. PHYSICIAN'S NAME (Type) <i>JAMES R. COLEMAN MD.</i>				22d. ADDRESS <i>9241 COLUMBIA BLVD SILVER SPRING, MD.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>Jan 27-1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>East Lincoln Crematory</i>				23d. LOCATION (City, town or county) (State) <i>Colmar Manor, Md</i>			
24. FUNERAL DIRECTOR <i>Santha Nallor</i>				ADDRESS <i>254 Canada St NW Wash. DC</i>				25a. REC'D BY REGISTRAR <i>Feb 1 1966</i>			
								25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

1888

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 M 90 0 1 22 VR A15 4 15M 9/60

00998

00973

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville				c. LENGTH OF STAY IN 1b 3 mos.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Homestead Nursing Home							
3. NAME OF DECEASED (Type or print) First Isobel Middle Carpenter Last Macon				4. DATE OF DEATH Month Jan. Day 27 Year 1966			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 25, 1890	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 6 Days 2		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY -			
11. BIRTHPLACE (County & State, or foreign country) Devils Lake, North Dakota				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Henry A. Carpenter				14. MOTHER'S MAIDEN NAME Mary Carpenter			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. unknown		17. INFORMANT Robert C. Macon Address Rockville, Md. 311 Broadwood Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4500							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10 - 1-26 , 1966 to 1-26 , 1966, that (I) (we) last saw the deceased alive on 1-26 , 1966, and that death occurred at 4 AM , from the causes and on the date stated above.							
22a. SIGNATURE D.L. Bucy				22b. DATE SIGNED 1-27-66			
22c. PHYSICIAN'S NAME (Type) D.L. Bucy				22d. ADDRESS 809 Venus Mill Rd Rockville			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-29-66		23c. NAME OF CEMETERY OR CREMATORY Washington Natl Cem.		23d. LOCATION (City, town or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				25a. REC'D BY REGISTRAR BETHESDA, Maryland FEB 4 1966 25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared by Coroner

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
00999									
00974									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>10 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>3971 Wendy Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>FRANCES</u> Last <u>Mahoney</u>					4. DATE OF DEATH Month <u>Jan.</u> Day <u>24</u> Year <u>66</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-14-84</u>		9. AGE (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Washington, DC,</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Michael J. MAHONEY</u>					14. MOTHER'S MAIDEN NAME <u>Catherine Hurley</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Margaret Atkinson</u>			Address <u>3871 Wendy Lane - SIL. SP. MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Myocardial infarction</u> DUE TO (b) <u>advanced coronary sclerosis</u> DUE TO (c) <u>5 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>June 20, 1956</u> to <u>Jan 24, 1966</u> , that (I) (we) last saw the deceased alive on <u>Jan 17, 1966</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>D.B. Washington</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/24/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>D.B. Washington M.D.</u>					22d. ADDRESS <u>5802 Rutledge Rd. Bethesda Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/27/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>			23d. LOCATION (City, town or county) (State) <u>BALTIMORE, MD</u>		
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS INC. SILVER SPRING MD</u>					25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		
					DATE <u>JAN 28 1966</u>				

CERTIFICATE OF DEATH

1912

1912

Blank form for Certificate of Death, featuring horizontal lines for text entry and two punch holes on the right side.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>3 1/2 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chovy Chase</u> <u>15-1</u> d. STREET ADDRESS <u>4757 Chovy Chase Dr.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lester</u> Middle <u>W.</u> Last <u>Manley</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>21</u> Year <u>1966</u>							
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 26 1904</u>		9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SELF</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Edwin Manley</u>						14. MOTHER'S MAIDEN NAME <u>Clara Backus</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>KATHERINE MANLEY - WIFE - SAME</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Myocardial Infarction</u> (c) <u>Arteriosclerotic Heart Disease</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs</u> <u>3 hrs.</u> <u>several</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u> </u> <u> </u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (the hospital) attended the deceased from <u>1963</u> to <u>Jan 21, 1966</u> , that (I) (the) last saw the deceased alive on <u>Jan 21, 1966</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>James W. Egan</u>						22b. DATE SIGNED <u>1/21/66</u>		22c. PHYSICIAN'S NAME (Type) <u>James W. Egan</u>			
22d. ADDRESS <u>5413 Cedar Lane - Bethesda Md.</u>						22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				23b. DATE THEREOF <u>1-24-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wyoming Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Melrose, Mass.</u>			
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> <u>5130 Wisc. Ave. N.W. Wash. D.C.</u>						25a. REC'D BY REGISTRAR <u>JAN 26 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

MEMORANDUM

CONFIDENTIAL

100-100000

[Faint, mostly illegible text body consisting of several paragraphs of a memorandum format.]

Very truly yours,
[Signature]
Special Agent in Charge

CONFIDENTIAL

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in an event within 72 hours after death.

Items 18&21 Film G373 2/5/66 TR

01001

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00976

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE Florida b. COUNTY Manatee			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN ID 1 day			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium				d. STREET ADDRESS 2011 - 1st Ave. East,			
3. NAME OF DECEASED (Type or print) First Mary Middle Agnes Last MANNING				4. DATE OF DEATH Month January Day 6th Year 19 66			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 17 Mar 1899	
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 9 Days 19		11. IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Medical Secretary			
11. BIRTHPLACE (State or foreign country) New York City, NY				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Henry A. Dickerson				14. MOTHER'S MAIDEN NAME Agnes V. Riggs			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 064-05-7285			
17. INFORMANT Patricia A. Gretz				Address Rockville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial insufficiency 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic heart disease DUE TO (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Reap				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (street, city, town, or county) Wheaton, Md.			
EXAMINER'S NAME (Type) Belden R. Reap				22. DATE SIGNED Jan. 7, 1966 11502 Grandview Wheaton, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/8/66		23c. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery		23d. LOCATION (City, town or county) (State) Gaithersburg, Maryland	
24. FUNERAL DIRECTOR Robert A. Pumphrey, Bethesda, Maryland				25e. REC'D BY REGISTRAR AN 10 1966			
25b. REGISTRAR'S SIGNATURE J. Williams Judge							

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Florida

Montgomery

Prohibition

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James P. ...

211 - 1st Ave. East

Washington ...

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IV Mar 1939

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Medical Secretary, New York City, N.Y.

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James V. ...

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Jan. 7, 1939
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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00977											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 3 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 10412 Montrose Ave.						d. STREET ADDRESS 10412 Montrose Ave.					
3. NAME OF DECEASED (Type or print) MARY SOPHIA MANNING						4. DATE OF DEATH Month Jan. Day 6, Year 19 66					
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 12, 1883		9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 7 Days 24	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer				10b. KIND OF BUSINESS OR INDUSTRY Beth.Steel Co.		11. BIRTHPLACE (County & State, or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME (Unknown) Urban						14. MOTHER'S MAIDEN NAME Mary Sophia (Unknown)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Daughter		Address Same as Item 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4330 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic cardiovascular dis (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic congestive heart failure & obesity										INTERVAL BETWEEN ONSET AND DEATH Instant Yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 1965 to 6 Jan 1966 , that (I) (we) last saw the deceased alive on 28 Dec 1965 , and that death occurred 5 PM , from the causes and on the date stated above.											
22a. SIGNATURE Horace W. Bernier						22b. DATE SIGNED 1/6/66					
22c. PHYSICIAN'S NAME (Type) HORACE W. BERNIER, MD						22d. ADDRESS 4443 BRADLEY BLVD, BETH, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 1-7-66				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City, town or county) Dauphin County, Penna.		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY						ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR JAN 10 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



Mr. Kennedy

Bethesda

10412 Rockledge Ave.

MARK

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(Unknown) Urban

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Mr. Kennedy

Bethesda

10412 Rockledge Ave.

MARK

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(Unknown) Urban

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
01003 Item #9 Film #G373 2/11/66				02510							
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN ID <u>18 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hillandale</u> d. STREET ADDRESS <u>1821 Powder Mill Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>LENNIE</u> Last <u>Manning</u>				4. DATE OF DEATH Month <u>January</u> Day <u>28</u> Year <u>1966</u>				5. SEX <u>Female</u> 6. COLOR OR RACE <u>Negro</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>2-7-1881</u> 9. AGE (In years last birthday) <u>85</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u> </u> 11. BIRTHPLACE (County & State, or foreign country) <u>Dillon, S. C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>United States</u>				13. FATHER'S NAME <u>Mack Alford</u> 14. MOTHER'S MAIDEN NAME <u>Dinah Bethea</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u> </u> 16. SOCIAL SECURITY NO. <u> </u> 17. INFORMANT <u>William S. Manning</u> Address <u>728 Rock Creek Church Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Ovary</u> <u>1750</u> DUE TO (b) <u>metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u> </u>											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>1/10</u> , 19 <u>66</u> , to <u>1/28</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1/22</u> , 19 <u>66</u> , and that death occurred at <u>3:26</u> AM, from the causes and on the date stated above.											
22a. SIGNATURE <u>Charles Judge</u>								22b. DATE SIGNED M.D. <u> </u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) <u>Charles Judge</u>								22d. ADDRESS <u> </u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u> 23b. DATE THEREOF <u>2-2-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>HARMONX</u> 23d. LOCATION (City, town or county) (State) <u>PR Geo's Co. Md.</u>				24. FUNERAL DIRECTOR <u>C. B. Carr</u> ADDRESS <u>289 R.I. Ave. N.W. Wash. D.C.</u> 25a. REC'D BY REGISTRAR <u>FEB 8 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

1117-1

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1117-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01004					00978						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY <u>Montgomery</u>					a. STATE <u>Maryland</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>					b. COUNTY <u>Montgomery</u>						
c. LENGTH OF STAY IN 1b <u>5 1/2 days</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanatorium & Hospital</u>					d. STREET ADDRESS <u>2507 Kimberly Street</u>						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Catherine</u>					4. DATE OF DEATH Month <u>1</u> Day <u>23</u> Year <u>1966</u>						
First <u>Umm</u> Middle <u>Manton</u> Last											
5. SEX <u>Female</u>					6. COLOR OR RACE <u>White</u>						
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>					8. DATE OF BIRTH <u>9-21-88</u>						
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>					9. AGE (In years last birthday) <u>77</u> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					11. BIRTHPLACE (County & State, or foreign country) <u>Rhode Island</u>						
10b. KIND OF BUSINESS OR INDUSTRY					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>						
13. FATHER'S NAME <u>Robert Henderson</u>					14. MOTHER'S MAIDEN NAME <u>Sarah Howe</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.						
17. INFORMANT <u>Records - Washington Sanatorium & Hospital</u>					Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHIAL CARCINOMA</u> <u>1621</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>										20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>DECEMBER, 1965</u> , to <u>1-23-66</u> , 19 <u>66</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>1-22</u> 19 <u>66</u> , and that death occurred at <u>9:52 AM</u> , from the causes and on the date stated above.										22b. DATE SIGNED	
22a. SIGNATURE <u>Marion C. Gunnarson</u>										22c. PHYSICIAN'S NAME (Type) <u>Marion C. Gunnarson</u>	
22d. ADDRESS <u>254 Carroll St NW</u>										22e. REC'D BY REGISTRAR <u>Jan 26 1966</u>	
22f. REGISTRAR'S SIGNATURE <u>John C. Judge</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>										23b. DATE THEREOF <u>JAN. 26-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Leo M. M. Cemetery</u>										23d. LOCATION (City, town or county) (State) <u>River Rd. Riverdale, Md.</u>	
24. FUNERAL DIRECTOR <u>John C. Judge</u>										24b. ADDRESS <u>254 Carroll St NW</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove registration papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

2

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>12 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>					d. STREET ADDRESS <u>9313 East Parkhill Dr.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Maurice</u> Middle <u>A</u> Last <u>MARTIN</u>					4. DATE OF DEATH Month <u>Jan</u> Day <u>28</u> Year <u>1966</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-4-94</u>		9. AGE (In years lost birthday) yrs. <u>71</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>C.R.N.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>ARTHUR MARTIN</u>					14. MOTHER'S MAIDEN NAME <u>Daisy Creighton</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-34-4845</u>		17. INFORMANT Address <u>Ethel K. Martin-Wife</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>ARTERIOSCLEROTIC cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>10.4</u> DUE TO <u>INTERVAL BETWEEN ONSET AND DEATH</u> (c) <u>10.4</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rt upper lobe pneumonia</u>									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec</u> , 19 <u>64</u> , to <u>28 Jan</u> , 19 <u>66</u> that (I) (we) saw the deceased alive on <u>27 Jan</u> 19 <u>66</u> , and that death occurred at <u>2:50</u> M, from causes on and on the date stated above.									
22a. SIGNATURE <u>H. W. Bernton</u>					22b. DATE SIGNED			22c. PHYSICIAN'S NAME (Type) <u>HORACE W. BERTON, M.D.</u>	
22d. ADDRESS <u>4743 BRADLEY BLVD. CH. CH.</u>					22e. MED. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-31-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>H. Lincoln</u>			23d. LOCATION (City or Town) (County) (State) <u>Prince Geo. Co. Maryland</u>		
24. FUNERAL DIRECTOR <u>H. Hon. DeVol</u> ADDRESS <u>N.M.</u>					25a. REC'D BY REGISTRAR <u>DATE 3 1956</u>		25b. REGISTRAR'S SIGNATURE <u>Richard Judge</u>		

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UNITED STATES DEPARTMENT OF HEALTH

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UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF PUBLIC HEALTH
DIVISION OF VITAL STATISTICS
WASHINGTON, D. C. 20001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01006

CERTIFICATE OF DEATH

00380

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u> c. LENGTH OF STAY IN 1b <u>8 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital of Silver Springs</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u> d. STREET ADDRESS <u>10202 South Moor Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>John</u> Middle <u>Mc Girk</u> Last <u>McCansland</u>		4. DATE OF DEATH <u>January 16, 1966</u> Month <u>January</u> Day <u>16</u> Year <u>1966</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-19-1890</u> 9. AGE (in years last birthday) <u>75</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Dentist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dentistry</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. McCansland</u>		14. MOTHER'S MAIDEN NAME <u>Laura Bell Hoop</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>579-52-6780</u>	
17. INFORMANT <u>Mary Virginia McCansland</u> Address <u>10202 Southmoor Silver Spring, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerotic heart disease with prior myocardial infarction</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 16, 1966</u> , to <u>Jan 16, 1966</u> , that (I) (we) last saw the deceased alive on <u>Jan 16, 1966</u> , and that death occurred at <u>11:02 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Sydney Leventhal</u>		22b. DATE SIGNED <u>Jan 16, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Sydney Leventhal, M.D.</u>		22d. ADDRESS <u>9210 Colesville Rd., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-18-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u> Address <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>J. Charles Judge</u> DATE <u>JAN 24 1966</u>	

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39610

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Montgomery</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>						c. LENGTH OF STAY IN lb <i>2 1/2 weeks</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>University Nursing Home</i>						d. STREET ADDRESS <i>10322 Leslie St</i> 15-1					
3. NAME OF DECEASED (Type or print) <i>First Middle McGarran Last</i>						4. DATE OF DEATH <i>Jan 3 1966</i> Month Day Year					
5. SEX <i>F</i>		6. COLOR OR RACE <i>Cauc</i>		7. <input checked="" type="checkbox"/> MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>Dec 24, 1883</i>		9. AGE (In years last birthday) <i>82</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>						10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Washington D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>	
13. FATHER'S NAME <i>John Cahice</i>						14. MOTHER'S MAIDEN NAME <i>Mary E. Carner</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give war or dates of service) <i>None</i>						16. SOCIAL SECURITY NO. <i>578-480435</i>		17. INFORMANT <i>Mrs. Loretta G. Quinn</i> Address <i>10322 Leslie Street Silver Spring, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>SEPTICEMIA</i> <i>5721</i> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>BOWEL ABSCESS.</i> DUE TO (c) <i>DIVERTICULITIS.</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>DEC 29th, 1965</i> , to <i>Jan 3rd, 1966</i> , that (I) (we) last saw the deceased alive on <i>JAN 3</i> 1966, and that death occurred at <i>1:20 PM</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>Robert Kramer</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>Robert Kramer</i>						22d. ADDRESS <i>8484 16th St. S.S. Md.</i>		22b. DATE SIGNED <i>1-3-1966</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>1-7-66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Washington D.C.</i>			
24. FUNERAL DIRECTOR <i>E. Glen Cuth</i> ADDRESS <i>8434 Georgia Avenue Warner E. Pumphrey, Inc. Silver Spring, Md.</i>						25a. REC'D BY REGISTRAR <i>JAN 10 1966</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			

12800

10010

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05982

01008

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 1b <i>11 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		15-1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Holy Cross Hospital</i>				d. STREET ADDRESS <i>601 Sligo Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Alice</i>		First <i>Nancy</i>		Middle <i>Mc Kenna</i>		Last	
4. DATE OF DEATH Month <i>January</i>		Day <i>5</i>		Year <i>19 66</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Sept 22, 1886</i>		9. AGE (In years last birthday) yrs. <i>79</i>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (State or foreign country) <i>Conn.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William H. Downes</i>				14. MOTHER'S MAIDEN NAME <i>Nancy J. Ives</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>042-05-2934-B</i>		17. INFORMANT <i>William J. Mc Kenna</i>			
				Address <i>8004 Park Crest Drive Silver Spring, Maryland</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Atherosclerotic Heart Disease</i> <i>4200</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Generalized arteriosclerosis</i> DUE TO (c) <i>Pleural effusion</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus</i> INTERVAL BETWEEN ONSET AND DEATH <i>Unknown</i>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>April</i> , 19 <i>67</i> , to <i>Jan 5</i> , 19 <i>66</i> , that I last saw the deceased alive on <i>Jan 4</i> , 19 <i>66</i> , and that death occurred at <i>Jan 5</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>10511 Summit Ave Kensington, Md 7 Jan 66</i>							
ACTUAL SIGNATURE <i>George Sharpe</i>		PHYSICIAN'S NAME (Type) <i>George Sharpe</i>		M.D. <i>10511 Summit Ave Kensington, Md</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1-8-66</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Silver Spring, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Pumphrey, Inc.</i>				ADDRESS <i>8434 Georgia Avenue Silver Spring, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 13 1966</i>	
				24b. REGISTRAR'S SIGNATURE <i>James Judge</i>			

TO HOSPITAL OR / TENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Date of death: _____

7. Time of death: _____

8. Cause of death: _____

9. Place of death: _____

10. Signature of physician: _____

11. Signature of registrar: _____

12. Signature of informant: _____

13. Name of informant: _____

14. Address of informant: _____

15. Date of completion: _____

RECORDED
INDEXED

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, 1906, AND THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, 1924, AND THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, 1934, AND THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, 1944, AND THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, 1954, AND THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, 1964, AND THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, 1974, AND THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, 1984, AND THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, 1994, AND THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, 2004, AND THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, 2014, AND THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, 2024.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div style="text-align: center;"> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div>																	
<div style="display: flex; justify-content: space-between;"> 01009 00983 </div>																	
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Montgomery</u> MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u></p> <p>c. LENGTH OF STAY IN 1b <u>4 mo.</u></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>University Nursing Home</u></p>						<p>2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)</p> <p>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> <u>15-1</u></p> <p>d. STREET ADDRESS <u>12043 Bridge Rd</u></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>											
<p>3. NAME OF DECEASED (Type or print)</p> <p>First <u>James</u> Middle <u>Henry</u> Last <u>McVey</u></p>			<p>4. DATE OF DEATH</p> <p>Month <u>JAN.</u> Day <u>14</u> Year <u>1966</u></p>			<p>5. SEX <u>Male</u></p>			<p>6. COLOR OR RACE <u>CAUC</u></p>			<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>					
<p>8. DATE OF BIRTH</p> <p><u>Feb. 8, 1892</u></p>			<p>9. AGE (In years last birthday) <u>73</u> yrs.</p>			<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer in Gov.</u></p>			<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u></p>			<p>11. BIRTHPLACE (County & State, or foreign country) <u>Washington D.C.</u></p>					
<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u></p>						<p>13. FATHER'S NAME <u>John Francis McVey</u></p>						<p>14. MOTHER'S MAIDEN NAME <u>Margaret Agnes Kerney</u></p>					
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u></p>						<p>16. SOCIAL SECURITY NO. <u></u></p>						<p>17. INFORMANT <u></u> Address <u></u></p>					
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>5020</u> <u>Emphysema</u></p> <p>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b) <u>Chronic Bronchitis</u></p> <p>(c) <u>Cancer of Prostate</u></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</p>																	
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>																	
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>																	
<p>20c. TIME OF INJURY Month, Day, Year</p> <p>Hour a.m. <u>19</u> p.m. <u></u></p>				<p>20d. INJURY OCCURRED</p> <p>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>				<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>				<p>20f. (City or town) (County) (State)</p>					
<p>21. I certify that (I) (this hospital) attended the deceased from <u>Feb 10, 1963</u>, to <u>Jan 14 1966</u>, that (I) (we) last saw the deceased alive on <u>Jan 14 1966</u>, and that death occurred at <u>6A</u> M, from the causes and on the date stated above.</p>																	
<p>22a. SIGNATURE <u>John J. Curry</u></p>								<p>22b. DATE SIGNED <u>1/14/66</u></p>									
<p>22c. PHYSICIAN'S NAME (Type) <u>John J. Curry</u></p>								<p>22d. ADDRESS <u>10620 Georgia Ave</u></p>									
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u></p>				<p>23b. DATE THEREOF <u>JAN. 17, 1966</u></p>				<p>23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u></p>				<p>23d. LOCATION (City, town or county) (State) <u>WASH. D. C.</u></p>					
<p>24. FUNERAL DIRECTOR <u>Thomas R. Haulon</u></p>								<p>25a. REC'D BY REGISTRAR <u>JAN 24 1966</u></p>				<p>25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u></p>					

8208

9010

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
01010 00984									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>14 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>9201 Sudbury Road</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>15-1</u> d. STREET ADDRESS <u>9201 Sudbury Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>MICHAEL Joseph MELLO</u> First Middle Last					4. DATE OF DEATH <u>January 10 19 66</u> Month Day Year				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 29, 1881</u>		9. AGE (in years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Midvale Steel Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Phila., Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Mello</u>					14. MOTHER'S MAIDEN NAME <u>Margaret Deppppp Durkin</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>159-07-2452A</u>		17. INFORMANT <u>Mrs. Marguerite Burke</u> <u>9201 Sudbury Road Silver Spring, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> <u>163X</u> DUE TO (b) <u>Carcinoma of lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Senile Atherosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>18 mos.</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Dehydration</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1963</u> to <u>JAN 10, 1966</u> , that (II) (we) last saw the deceased alive on <u>JAN 9 1966</u> , and that death occurred at <u>5:45 AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Raymond O. West</u>					22b. DATE SIGNED <u>1-11-66</u>				
22c. PHYSICIAN'S NAME (Type) <u>Raymond O. West</u>					22d. ADDRESS <u>831 University Blvd. E., Hyattsville, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-13-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Silver Spring, Maryland</u>			
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>					25a. REC'D BY REGISTRAR <u>17 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		

08200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Dr. Ball notified and approved.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00985											
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>DC</i> b. COUNTY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>				c. LENGTH OF STAY IN 1b <i>6 weeks</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>WASHINGTON DC 47-3</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Patomac Valley Nursing Home</i>				d. STREET ADDRESS <i>1722 - 19th St NW</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>MAUDE CLAVIN MERRICK</i>				4. DATE OF DEATH Month Day Year <i>Jan. 14 1966</i>							
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>11/22/74</i>		9. AGE (In years last birthday) <i>91</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secretary,</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Radio/Television</i>				11. BIRTH PLACE (County & State, or foreign country) <i>Iowa</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Thomas E. Cavin</i>				14. MOTHER'S MAIDEN NAME <i>Emma L. Field</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>577 05 8878A</i>				17. INFORMANT <i>Bethesda Address Maryland.</i> <i>Mrs. Marjorie Geddes, 4609 Bayard Blvd</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4221 Congestive Heart Failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO (c) <i>Generalized Atherosclerosis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cerebral Thrombosis 1-11-66 2 shifts aft hemiparesis</i>										INTERVAL BETWEEN ONSET AND DEATH <i>2 mos.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>January, 1958</i> , to <i>1-14-</i> , 1966, that (I) (we) last saw the deceased alive on <i>1-11</i> , 1966, and that death occurred at <i>9a</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>Edwin P. Parker</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <i>1-14-66</i>			
22c. PHYSICIAN'S NAME (Type) <i>Edwin P. Parker, M.D.</i>				22d. ADDRESS <i>2015 R St. NW, Washington, D.C.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>				23b. DATE THEREOF <i>Jan. 17, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>		23d. LOCATION (City, town or county) (State) <i>Suitland, Maryland.</i>			
24. FUNERAL DIRECTOR <i>Robert A. DeVol</i>				ADDRESS <i>Home WASH D.C.</i>				25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE	
								DATE <i>JAN 19 1966</i>			

1887

WEST

1887

[Faint, mostly illegible text covering the main body of the page, possibly a list or report.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

BP

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
01012		00986							
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>✓</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>10 Days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>4402 Bowen Road, S.E. 47-3</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>					d. STREET ADDRESS <u>Washington, D.C.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert Howard Metcalfe</u>			First Middle Last		4. DATE OF DEATH <u>January 15 19 66</u>		Month Day Year		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>28 November 1949</u>		9. AGE (In years last birthday) <u>16 yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>----</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Charles H. Metcalfe</u>					14. MOTHER'S MAIDEN NAME <u>Eleanor Curtin</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> 7573 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Uremia</u> DUE TO (c) <u>Solitary hypoplastic kidney</u>									INTERVAL BETWEEN ONSET AND DEATH <u>30 Minutes</u> <u>3 months</u> <u>16 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <u>X</u> (this hospital) attended the deceased from <u>5 January 19 66</u> , to <u>15 January 19 66</u> , that <u>10</u> (we) last saw the deceased alive on <u>15 January 19 66</u> , and that death occurred at <u>5:10M</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Ronald T. Rolley</u>					22b. DATE SIGNED <u>16 January 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>Ronald T. Rolley, M.D.</u>		
22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>1/19/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>			23d. LOCATION (City, town or county) (State) <u>SUITHLAND MD.</u>		
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS CO. INC.</u>		ADDRESS <u>517 11TH ST. S.E. WASH. D.C.</u>		25a. REC'D BY REGISTRAR <u>16 JAN 20 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

23200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01013					00987						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b		a. STATE		b. COUNTY		
Montgomery		Silver Spring					Maryland		Montgomery		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
807 Stirling Road					807 Stirling Road					15-1	
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH		
			Louis		F.		Miller		January 25 1966		
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10-21-1883		82 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Brick Mason & Tile Setter						Michigan			U.S.A.		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
Louis Miller						Elizabeth Felbel					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT					
No				577-10-9543		Mrs. Frances M. Witkop, 2559 Albert Drive, S.E., Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <i>Acute Congestive Heart Failure</i>										1 Hr	
DUE TO (b) <i>Malignancy of Liver</i>										3 Mo	
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m. 19				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from <i>Nov</i> , 19 <i>65</i> , to <i>Jan 25</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>1/25</i> 19 <i>66</i> , and that death occurred at <i>6 PM</i> , from the causes and on the date stated above.											
22a. SIGNATURE								ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
<i>Harold Heiger</i>								M.D.		1/25/66	
22c. PHYSICIAN'S NAME (Type)								22d. ADDRESS			
Harold Heiger								1835 Eye St NW			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)			
Removal			1-28-1966					Saronac, Michigan			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Joseph Gawler's Sons, Inc.						5130 Wisc. Ave. N.W., Wash. D.C.		DATE FEB 1 1966 <i>Charles Judge</i>			

MEDICAL CERTIFICATION

80087

0101

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01014

CERTIFICATE OF DEATH

00988

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5123 Bradley Blvd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Carolyn Middle Reed Last MILLER		4. DATE OF DEATH Month January Day 2 Year 1966					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 1, 1880	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months 2 Days 1 Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Fairmount, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas Reed				14. MOTHER'S MAIDEN NAME Harriet Turney			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 173-18-3084		17. INFORMANT Mrs. Harriet M. Hyre, Chevy Chase, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MALIGNANT CACHEXIA 151X DUE TO (b) CARCINOMA OF STOMACH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIOSCLEROSIS GENERAL AND CEREBRAL							INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS 1 YEAR
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from APRIL 14, 1963 , to JAN. 2, 1966 , that (I) (we) last saw the deceased alive on DEC. 24, 1965 , and that death occurred at 12:45 M, from the causes and on the date stated above.							
22a. SIGNATURE Robert G. Angle				22b. DATE SIGNED JAN. 2, 1966		22c. PHYSICIAN'S NAME (Type) Robert G. Angle	
22d. ADDRESS 5009 DeRay Ave., Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 5, '66		23c. NAME OF CEMETERY OR CREMATORY Lawnwood Cemetery		23d. LOCATION (City, town or county) (State) Morgantown, W. Va.	
24. FUNERAL DIRECTOR Robt. A. Pumphrey, Bethesda, Maryland				25a. REC'D BY REGISTRAR JAN 5 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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STATE OF DEAN

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Robert G. Smith

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Robert G. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01015					00989				
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>DC.</u> b. COUNTY <u>✓</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lakewood Park</u>			c. LENGTH OF STAY IN 1b <u>5 months</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington 47-3</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Oakhaven Convalescent Home</u>					d. STREET ADDRESS <u>254 Madison N.W.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Roland</u> First <u>Mills</u> Middle <u>Mills</u> Last			4. DATE OF DEATH <u>Jan</u> Month <u>30</u> Day <u>1966</u> Year						
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 29 1895</u>	9. AGE (In years last birthday) <u>70</u> yrs.	10. FINDER 1 YEAR Months <u>70</u> Days <u>70</u> Hours <u>70</u> Min.	11. FINDER 24 HRS. Months <u>70</u> Days <u>70</u> Hours <u>70</u> Min.	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Metal lather</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Robert Wyatt Mills</u>			14. MOTHER'S MAIDEN NAME <u>Alvena Burton Mills</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>			16. SOCIAL SECURITY NO. <u>1916-1918</u>		17. INFORMANT <u>Jane Moore</u> Address <u>254 Madison N.W. Wash. DC</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>334X</u> DUE TO <u>Emphysema</u> (b) <u>Cerebral arteriosclerosis</u> DUE TO <u>334X</u> (c) <u>334X</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>19</u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>8/6/65</u> , 19 <u>65</u> , to <u>1/30/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1/20/66</u> , 19 <u>66</u> , and that death occurred at <u>8:15</u> A.M. from the causes and on the date stated above.									
22a. SIGNATURE <u>Chas H Woloshon</u>			M.D. ATTENDING PHYS. <input type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/30/66</u>				
22c. PHYSICIAN'S NAME (Type) <u>Chas H Woloshon</u>			22d. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>2/3/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>		
24. FUNERAL DIRECTOR <u>W R Huntman</u>			ADDRESS <u>San Funeral Home, 1130 Georgia Ave, Wash, DC</u>		25a. REC'D BY REGISTRAR <u>FEB 4 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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01010

CERTIFICATE OF DEATH

Reg. Dist. No. 00990

01016

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wisc. Ave Congressional Manor Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BERTHA FISHER MOODY</u>		4. DATE OF DEATH <u>JANUARY 15 1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 6, 1871</u>
9. AGE (In years lost birthday) <u>94</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>J. V. FISHER</u>		14. MOTHER'S MAIDEN NAME <u>Jennie COTTER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>J. Fisher Moody (son)</u>		Address <u>5376-28th N.W. WASH. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cerebral Apoplexy</u> DUE TO <u>Cerebral Arteriosclerosis and</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>generalized Arteriosclerosis</u> (b) <u>Chronic</u> (c) <u>Chronic</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<u>Arterial Hypertension</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN. 6, 1966</u> to <u>JAN. 15, 1966</u> , that I last saw the deceased alive on <u>JAN. 13, 1966</u> , and that death occurred at <u>9:50 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. W. Nicklas</u>		ADDRESS (Street, city or town, state) <u>4830 V St. N.W. WASH. D.C.</u>	
PHYSICIAN'S NAME (Type) <u>Edward W. Nicklas</u>		DATE SIGNED <u>1/15/66</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-19-1966</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington Memorial Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Hyattsville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gawler's Sons, Inc.</u>		24a. REC'D BY REGISTRAR <u>J. Charles Judge</u>	
5130 Wisconsin Ave. N.W. WASH. D.C.		DATE <u>JAN 19 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

Reg. Dist. No. 00991

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON 42-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CHEVY CHASE NURSING HOME</u>		d. STREET ADDRESS <u>6101-29TH ST., N.W.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Roxie I Moore</u>		4. DATE OF DEATH Month Day Year <u>January 4 1966</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAUC.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 28, 1892</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>POST OFFICE</u>	
11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>MARY EARNHARDT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MRS. JOHN BLISH - SAME AS ITEM #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 7, 1963</u> , to <u>January 4, 1966</u> , that I last saw the deceased alive on <u>January 1, 1966</u> , and that death occurred at <u>4:54 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert B. Havell</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>5516 Nebraska Ave DC 1-7-66</u>	
PHYSICIAN'S NAME (Type) <u>Robert B. Havell MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1-6-66</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CHRISTIANIA CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>FAITH, N.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Lawler's Son</u>		24a. REC'D BY REGISTRAR <u>JAN 10 1966</u>	24b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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 This is to certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the State of Maryland, and that the same has been compared with the original and found to be a true and correct copy of the original as the same appears in the records of the State of Maryland.

CERTIFICATE OF DEATH

PLACE OF BIRTH		DATE OF BIRTH	
SEX		RACE	
EDUCATION		OCCUPATION	
MARRIED		SINGLE	
PREVIOUS MARRIAGES		CAUSE OF DEATH	
DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		TEMPERATURE	
PULSE		RESPIRATION	
BLOOD PRESSURE		WEIGHT	
HEIGHT		HAIR	
EYES		TEETH	
SKIN		MUCOUS MEMBRANES	
HEART		LUNGS	
LIVER		SPLEEN	
PANCREAS		GASTROINTESTINAL	
URINARY		GENITAL	
NEUROLOGICAL		PSYCHIATRIC	
SOCIAL HISTORY		FAMILY HISTORY	
PERSONAL HISTORY		MEDICAL HISTORY	
SURGICAL HISTORY		DENTAL HISTORY	
ALLERGIC HISTORY		VACCINATION HISTORY	
LABORATORY TESTS		IMMUNIZATION RECORD	
PATHOLOGICAL FINDINGS		MICROSCOPIC FINDINGS	
HISTOPATHOLOGICAL FINDINGS		CYTOLOGICAL FINDINGS	
BACTERIOLOGICAL FINDINGS		VIROLOGICAL FINDINGS	
SEROLOGICAL FINDINGS		IMMUNOLOGICAL FINDINGS	
GENETIC FINDINGS		ENVIRONMENTAL FINDINGS	
NUTRITIONAL FINDINGS		TOXICOLOGICAL FINDINGS	
PHARMACOLOGICAL FINDINGS		PSYCHOLOGICAL FINDINGS	
SOCIAL FINDINGS		LEGAL FINDINGS	
ETHICAL FINDINGS		MORAL FINDINGS	
RELIGIOUS FINDINGS		CULTURAL FINDINGS	
LIFESTYLE FINDINGS		HOBBIES FINDINGS	
INTERESTS FINDINGS		ACHIEVEMENTS FINDINGS	
RELATIONS FINDINGS		FRIENDS FINDINGS	
FAMILY FINDINGS		COMMUNITY FINDINGS	
CULTURE FINDINGS		ARTS FINDINGS	
SPORTS FINDINGS		GAMES FINDINGS	
TRAVEL FINDINGS		ADVENTURE FINDINGS	
EDUCATION FINDINGS		SKILLS FINDINGS	
KNOWLEDGE FINDINGS		WISDOM FINDINGS	
CHARACTER FINDINGS		TEMPERAMENT FINDINGS	
PERSONALITY FINDINGS		BEHAVIOR FINDINGS	
MANNERS FINDINGS		CUSTOMS FINDINGS	
TRADITIONS FINDINGS		RITUALS FINDINGS	
FESTIVALS FINDINGS		CELEBRATIONS FINDINGS	
HOLIDAYS FINDINGS		SABBATHS FINDINGS	
RELIGIOUS FINDINGS		SPIRITUAL FINDINGS	
PHILOSOPHY FINDINGS		LIFE FINDINGS	
DEATH FINDINGS		AFTERLIFE FINDINGS	
REBIRTH FINDINGS		RESURRECTION FINDINGS	
JUDGMENT FINDINGS		PARADISE FINDINGS	
HELL FINDINGS		PURGATORY FINDINGS	
HEAVEN FINDINGS		GARDEN FINDINGS	
TRAIL FINDINGS		GATE FINDINGS	
DOOR FINDINGS		WINDOW FINDINGS	
FLOOR FINDINGS		CEILING FINDINGS	
WALL FINDINGS		ROOF FINDINGS	
FOUNDATION FINDINGS		STRUCTURE FINDINGS	
DESIGN FINDINGS		STYLE FINDINGS	
COLOR FINDINGS		TEXTURE FINDINGS	
SMELL FINDINGS		TASTE FINDINGS	
SOUND FINDINGS		VIBRATION FINDINGS	
LIGHT FINDINGS		SHADOW FINDINGS	
HEAT FINDINGS		COLD FINDINGS	
WIND FINDINGS		RAIN FINDINGS	
SUN FINDINGS		MOON FINDINGS	
STARS FINDINGS		PLANETS FINDINGS	
GALAXIES FINDINGS		UNIVERSE FINDINGS	
COSMOS FINDINGS		COSMOS FINDINGS	

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
01018					CERTIFICATE OF DEATH					00992				
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>1 Hr., 10 Mins.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> d. STREET ADDRESS <u>Route #3, Box 289</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>Deborah Elizabeth Musser</u>					4. DATE OF DEATH Month Day Year <u>January 5 19 66</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8 September 1946</u>		9. AGE (In years last birthday) <u>19</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>----</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>						
13. FATHER'S NAME <u>Henry M. Musser, Jr.</u>					14. MOTHER'S MAIDEN NAME <u>Henrietta Glover</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>--</u>					16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 2927 DUE TO (b) <u>Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Congenital Hypoplastic Anemia</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>17 months</u> <u>19 years</u>														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>5 January, 1966</u> , to <u>5 January, 1966</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>5 January 1966</u> , and that death occurred at <u>10:55</u> from the causes and on the date stated above.														
22a. SIGNATURE <u>Dale H. Cowan</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>								22b. DATE SIGNED <u>6 January 1966</u>						
22c. PHYSICIAN'S NAME (Type) <u>Dale H. Cowan, M.D.</u>								22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>1-8-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Park Lawn</u>		23d. LOCATION (City, town or county) (State) <u>Rockville Md</u>								
24. FUNERAL DIRECTOR <u>James E. Gartner Gaithersburg Md</u> ADDRESS						25a. REC'D BY REGISTRAR <u>10 1966</u> DATE		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>						

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p style="margin: 0;">MARYLAND STATE DEPARTMENT OF HEALTH</p> <p style="margin: 0;">DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> </div> <div style="text-align: center;"> <p style="margin: 0; font-size: 1.2em;">CERTIFICATE OF DEATH</p> </div> <div style="text-align: right;"> <p style="margin: 0; font-size: 1.2em;">00993</p> </div> </div>															
<p>1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND</p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u></p> <p>c. LENGTH OF STAY IN lb <u>4 wks</u></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington JAN + Hosp.</u></p>				<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u></p> <p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> Washington, D.C. <u>47-3</u></p> <p>d. STREET ADDRESS <u>1100 Holly St. N.W. Wheaton</u></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>											
<p>3. NAME OF DECEASED (Type or print) First Middle Last <u>ELSIE</u> <u>Rebecca</u> <u>LEE</u> <u>NEWHAM</u></p>				<p>4. DATE OF DEATH Month Day Year <u>1</u> <u>9</u> <u>1966</u></p>				<p>5. SEX <u>Fe.</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>				<p>8. DATE OF BIRTH <u>8-24-88</u> 9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.</p>			
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Credit Manager</u></p>				<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Jelett's</u></p>				<p>11. BIRTHPLACE (County & State, or foreign country) <u>Wash. D.C.</u></p>				<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>			
<p>13. FATHER'S NAME <u>JAMES C. LEE</u></p>				<p>14. MOTHER'S MAIDEN NAME <u>Elizabeth Bartlett</u></p>											
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) <u>None</u></p>				<p>16. SOCIAL SECURITY NO. <u>YES</u></p>				<p>17. INFORMANT Address <u>Mrs. Alice Swingle</u> <u>8308 9th Avenue</u> <u>Wheaton, Md.</u></p>							
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Bronchial Pneumonia</u> <u>491X</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) DUE TO _____</p>															
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Congestive Heart Failure</u></p>															
<p>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/></p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)</p>											
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u></p>				<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>				<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>				<p>20f. (City or town) (County) (State)</p>			
<p>21. I certify that (I) (this hospital) attended the deceased from <u>12-13</u>, 19<u>65</u>, to <u>1-9</u>, 19<u>66</u>, that (I) (we) last saw the deceased alive on <u>1-8</u>, 19<u>66</u>, and that death occurred at <u>11:55 AM</u>, from the causes and on the date stated above.</p>															
<p>22a. SIGNATURE <u>Stuart Nelson</u></p>								<p>22b. DATE SIGNED <u>1-9-66</u></p>							
<p>22c. PHYSICIAN'S NAME (Type) <u>Stuart Nelson</u></p>								<p>22d. ADDRESS <u>831 University Blvd. E., S. S., Md.</u></p>							
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>				<p>23b. DATE THEREOF <u>1-12-66</u></p>				<p>23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u></p>				<p>23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u></p>			
<p>24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc.</u></p>				<p>25a. REC'D BY REGISTRAR <u>17</u> DATE <u>1966</u></p>				<p>25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u></p>							

53290

01020

CERTIFICATE OF DEATH

Reg. Dist. No. 00394

Item #14 Film #G373 2/15/66 pc

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b 15-1		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		d. STREET ADDRESS 5200 Falmouth Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDWIN Middle MARK Last NIESS		4. DATE OF DEATH Month Jan. Day 27 Year 1966		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-20-1893		9. AGE (In years last birthday) yrs. 72		10. IF UNDER 1 YEAR Months 72 Days 72 Hours 72 Min. 72	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Civil Service		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Edwin A. Niess		14. MOTHER'S MAIDEN NAME Carrie Virginia Carroll/Carvell		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes-WW I; 1917-1918		16. SOCIAL SECURITY NO. 577-58-2674	
17. INFORMANT 5200 Falmouth Rd. Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic heart failure 4201 DUE TO (b) Generalized arteriosclerosis DUE TO (c) and coronary artery disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinson's disease		INTERVAL BETWEEN ONSET AND DEATH months years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from Jan. 1-26-66 to Jan. 26-66 , that I last saw the deceased alive on Jan. 1-26-66 , and that death occurred at 345A AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 4400 49th St NW Washington D C		DATE SIGNED 1-27-66		ACTUAL SIGNATURE C P Ryland		PHYSICIAN'S NAME (Type) C P RYLAND		22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
22b. DATE THEREOF 1-29-1966		22c. NAME OF CEMETERY OR CREMATORY Warrenton, V a.		22d. LOCATION (City, town, or county) (State) Warrenton, Va.		23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's Sons, Inc.		24. REC'D BY REGISTRAR 6-13-66		25. REGISTRAR'S SIGNATURE Charles Judge		26. REGISTRAR'S SIGNATURE Charles Judge		27. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Chronic heart failure
myocardial infarction
and coronary artery disease
hypertension

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Hospitals and D

1-26-66
4:00 - 4:30 PM
G P Ryland
G P Ryland

CERTIFICATE OF DEATH

Reg. Dist. No. 00995

01021

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sumner				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sumner			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5008 Scarsdale Road				d. STREET ADDRESS 5008 Scarsdale Road			
3. NAME OF DECEASED (Type or print) First EDWARD Middle P. Last O'CONNELL				4. DATE OF DEATH Month Jan. Day 24 Year 1966			
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 22, 1907	9. AGE (In years lost birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Jeremiah O'Connell				14. MOTHER'S MAIDEN NAME Margaret Roberts			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 578-07-7587		17. INFORMANT Margaret Lohrmeyer, Sumner, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of the prostate with metastases 1561 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 29 Dec 1965 to 21 Jan 1966 , that I last saw the deceased alive on 21 Jan 1966 , and that death occurred at 11:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Robert C. Haile, M.D. 35 N. 1st St. Wash, D.C. 20001							
ACTUAL SIGNATURE Robert C. Haile, M.D.							
PHYSICIAN'S NAME (Type) Robert C. Haile, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/27/66		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE R. J. Murphy				ADDRESS 3524 Columbia Pike Arlington, Virginia		24a. REC'D BY REGISTRAR DATE 528 1 1966	
				24b. REGISTRAR'S SIGNATURE J. J. Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Cleared by Dr. W. Reap for Dr. J. Smith to sign Certificate.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
01022					CERTIFICATE OF DEATH					00996				
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San. & Hosp.</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fairland</u> 15-1 d. STREET ADDRESS <u>13100 Old Columbia Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>HARRY DAVID ODEN</u> First Middle Last 4. DATE OF DEATH <u>1 - 30 - 1966</u> Month Day Year					5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>3-17-10</u> 9. AGE (In years last birthday) <u>55</u> yrs. 10. IF UNDER 1 YEAR: Months <u>10</u> Days <u>13</u> Hours <u></u> Min. <u></u> 11. BIRTHPLACE (County & State, or foreign country) <u>Bethesda, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>Raymond Oden</u> 14. MOTHER'S MAIDEN NAME <u>Laura Carson</u>					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> 1942 16. SOCIAL SECURITY NO. <u>578-03-7774</u> 17. INFORMANT <u>Raymond Oden Rt. 29. Burtonsville Md.</u> Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Respiratory Failure</u> <u>1621</u> DUE TO (b) <u>Bronchogenic Carcinoma of Lungs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>										INTERVAL BETWEEN ONSET AND DEATH <u></u>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u></u> p.m. <u></u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u> 20f. (City or town) (County) (State)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21. I certify that (I) (this hospital) attended the deceased from <u></u> , 19 <u></u> , to <u></u> , 19 <u></u> , that (I) (we) last saw the deceased alive on <u>19</u> and that death occurred at <u></u> M, from the causes and on the date stated above.										22a. SIGNATURE <u>Joseph E. Smith, Jr.</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>2/11/66</u> 22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Smith, Jr.</u> 22d. ADDRESS <u>Burtonsville, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>2/4/66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u> ADDRESS <u>Bethesda, Md.</u> 23d. LOCATION (City, town or county) (State) <u>Arlington Va.</u>					25a. REC'D BY REGISTRAR <u>FEB 7 1966</u> 25b. REGISTRAR'S SIGNATURE <u></u>									

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01038

DAVID BERN

W M

Went to school

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-21 Film G373 009866 57
MONTGOMERY STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00997

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>DOA.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San + Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park 16-2</u> d. STREET ADDRESS <u>6821 Red Top Rd. apt 1-1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FREDERICK NORMAN O'DONNELL JR.</u> First Middle Last		4. DATE OF DEATH <u>1 24 1966</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>-AA- W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-16-65</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>3</u> yrs. IF UNDER 1 YEAR <u>3</u> Months <u>8</u> Days IF UNDER 24 HRS. <u>3</u> Hours <u>1</u> Min.
11. BIRTHPLACE (State or foreign country) <u>Wash D.C.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frederick Norman O'Donnell</u>		14. MOTHER'S MAIDEN NAME <u>Judie Giley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Frederick O'Donnell</u>	
17. INFORMANT <u>Frederick O'Donnell</u>		Address <u>Same as 12</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia due to asphyxia, accidental.</u> 9240 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Deceased infant suffocated accidentally in bed.</u>	
20c. TIME OF INJURY Month, Day, Year <u>3:00 a.m. 1/24 1966</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Takoma Pk. Pr. Goe. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u>		22. DATE SIGNED <u>JAN. 24, 1966</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Wash D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-26-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Wash D.C.</u>		23d. LOCATION (City, town or county) (State) <u>Wash. D.C.</u>	
24. FUNERAL DIRECTOR <u>Phyllis A. Hattin</u>		25a. REC'D BY REGISTRAR <u>JAN 28 1966</u>	
ADDRESS <u>Wash D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

60937

PHYSICAL EXAMINER'S CERTIFICATE OF DEPT. OF HEALTH

0123

NEW YORK

[Faint, mostly illegible handwritten text, likely a medical examination report or certificate.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01024 CERTIFICATE OF DEATH 00998											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u>					c. LENGTH OF STAY IN 1b <u>16-2</u>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>					d. STREET ADDRESS <u>1108 Navahoe Drive</u>						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Harry P Ostwalt</u>					4. DATE OF DEATH <u>Jan 8 1966</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 26, 1890</u>		9. AGE (In years last birthday) <u>75</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Pipe Foundry</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>--Guttsmann</u>					14. MOTHER'S MAIDEN NAME <u>---Ostwalt</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>					16. SOCIAL SECURITY NO. <u>570-40-3778</u>		17. INFORMANT <u>Eva Ostwalt</u> Address <u>same item #2</u> (Wife)				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEPATIC COMA</u> <u>1909</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>METASTATIC MELANOMA</u> DUE TO (c) <u>2 months</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1-8-66</u> to <u>1-8-66</u> , that (I) (we) last saw the deceased alive on <u>1-8-66</u> , and that death occurred at <u>10:15 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Morton W. Shapiro</u> M.O.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Morton W. Shapiro, M.D.</u>					22d. ADDRESS <u>8107 Eastern Ave., Silver Spring, Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>					23b. DATE THEREOF <u>1/12/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		23d. LOCATION (City, town or county) (State) <u>Silver Spring, Md.</u>		
24. FUNERAL DIRECTOR <u>Wynson Wheeler Funeral Home</u>					1331 ADDRESS <u>Rockville, Md.</u>		25a. REC'D BY REGISTRAR <u>Jan 12 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		

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01084

Montgomery

Montgomery

Silver Spring

Silver Spring, Md

High Cross Hospital

1108 Riverside Dr

Jan

Ostwalt

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Hardy

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And at 1890

25

Life Foundation (Germany)

Active

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form #13. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01025

00999

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> c. LENGTH OF STAY IN 1b <i>44 days</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i> 15-1 d. STREET ADDRESS <i>10517 Seven Locks Rd</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>David</i> First Middle Last 4. DATE OF DEATH <i>Jan 7 1966</i> Month Day Year		5. SEX <i>M</i>		6. COLOR OR RACE <i>Cel</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>5/24/24</i> last birthday 9. AGE <i>41</i> years <i>10</i> months <i>15</i> days <i>15</i> hours <i>15</i> min. IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Payne</i>				14. MOTHER'S MAIDEN NAME <i>Florence McKens</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>981X Acute Purulent Peritonitis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Gunshot wound, Abdomen</i> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2 mo.</i> <i>1 1/2 mo</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Shot in abdomen with 22 cal. pistol by brother.</i>					
20c. TIME OF INJURY Month, Day, Year <i>9:30 p.m. Nov 24 1965</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) (County) (State) <i>Rockville - Mont. Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John S. Ball</i>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED <i>1/8/66</i>	
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1/12/66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lincoln Park</i>		23d. LOCATION (City, town or county) (State) <i>Rockville, Md.</i>			
24. FUNERAL DIRECTOR <i>George R. Snowden</i>				ADDRESS <i>Rockville Md.</i>		25a. REC'D BY REGISTRAR <i>JAN 12 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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ALBERT E. WINSTON'S CERTIFICATE OF DEATH

01052

NO. 1000
IN THE CITY OF

[Faint, mostly illegible handwritten text, likely a death certificate form with fields for name, date, and location.]

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

01026

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01000

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Me.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. LENGTH OF STAY IN 1b. <u>5 yr.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		d. STREET ADDRESS <u>3607 Shepherd St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3607 Shepherd St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Genevra</u> Middle <u>W.</u> Last <u>Peck</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>30</u> Year <u>1966</u>	
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/25/1907</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Syracuse, N. Y.</u>
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Otis M. Wiley</u>		14. MOTHER'S MAIDEN NAME <u>Genevra G. Gwynn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Husband</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of Lungs</u> DUE TO (b) <u>Carcinoma Left Breast</u> DUE TO (c) <u>170 X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u> <u>2 1/2 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22. DATE SIGNED <u>1/30/66</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>1/31/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince George Co.</u>
24. FUNERAL DIRECTOR <u>The S. H. Hines Co.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 4 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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STANDARD, N. T.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01027
CERTIFICATE OF DEATH
01001

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover 16-2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>3502 Hubbard Rd</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Katherine Cecelia Plitt</u>				4. DATE OF DEATH Month Day Year <u>January 27 1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 26, 1966</u>	
9. AGE (In years last birthday) yrs. <u>19</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>4</u>		IF UNDER 24 HRS. Hours <u>19</u> Min. <u>43</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Co Md</u>	
13. FATHER'S NAME <u>Gordon F. Plitt</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Father</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonitis, aspiration meconium</u> 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>20 hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Anoxia</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/26</u> , 19 <u>66</u> , to <u>1/27</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1/27</u> , 19 <u>66</u> , and that death occurred at <u>10:30</u> A.M., from the causes and on the date stated above.							
22a. SIGNATURE <u>M. Shapiro</u>				22b. DATE SIGNED <u>1/27/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Melvin Shapiro</u>				22d. ADDRESS <u>1040 University Blvd, East.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 29, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Colmar Manor, Md.</u>	
24. FUNERAL DIRECTOR <u>F. Herchison</u>				ADDRESS <u>4739 Balt. Ave, Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 1 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01028

01002

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont. Co.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cabin John</u>		
c. LENGTH OF STAY in lb <u>18 days</u>			d. STREET ADDRESS <u>6511-78th. street</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Reason P. Prather</u>			4. DATE OF DEATH <u>Jan. 23 1966</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/7/89</u>		9. AGE (In years last birthday) <u>77</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter & Coaster, Amusement Park</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia U.S.A.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Frank Prather</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Rutherford</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-01-0289</u>		17. INFORMANT <u>Franklin N. Prather</u> Address <u>150N</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic heart disease</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes mellitus</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>15 Jan 1966</u> , to <u>23 Jan 1966</u> that (I) (we) last saw the deceased alive on <u>23 Jan 1966</u> , and that death occurred at <u>3:07 P</u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>John Maylath</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>23 Jan 66</u>	
22c. PHYSICIAN'S NAME (Type) <u>John Maylath</u>		22d. ADDRESS <u>50 W. Edmonston Dr., Rockville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/27/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Shepherdstown Reform</u>	23d. LOCATION (City or Town) <u>Shepherdstown, W.Va.</u> (County) (State)		
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 26 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

Item #051m#G373 2/3/66 p101033											
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
Died 1-24-66 at 10:50 PM											
1. PLACE OF DEATH a. COUNTY Montgomery						2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Md.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring.					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wash. San. & Hosp.						d. STREET ADDRESS 10211 Southmoor Drive					
3. NAME OF DECEASED (Type or print) First Middle Last William CRAWFORD Pruitt						4. DATE OF DEATH Month Day Year 1 24 1966					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/22/86		9. AGE (In years last birthday) 78 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Public Watchman				10b. KIND OF BUSINESS OR INDUSTRY American Instrument Co.				11. BIRTHPLACE (County & State, or foreign country) Oxford, N. Carolina		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME James B. Pruitt						14. MOTHER'S MAIDEN NAME Lucy Cunnan					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Ruth Roundy - daughter		Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT 4201 DUE TO Arteriosclerosis, General Died 10:50 PM on 1-24-66 DUE TO Died 10:50 PM on 1-24-66 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Released by Coroner Dr. Belden Prays										INTERVAL BETWEEN ONSET AND DEATH 2 minutes 20 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Sept 1962 to 1-24-1966 that (I) last saw the deceased alive on Jan 20 1966, and that death occurred at 10:50 PM from the causes and on the date stated above.											
22a. SIGNATURE George B. Patrick, Jr.										22b. DATE SIGNED 1-24-66	
22c. PHYSICIAN'S NAME (Typed) George B. Patrick, Jr., MD				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS 9221 Cokesville Rd, Silver Spring, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 27, 1966		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery				23d. LOCATION (City, town or county) (State) Prince Georges County			
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc., 8434 Ga., Ave., S.S.						25a. REC'D BY REGISTRAR MBAN 28 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

Handwritten text, mostly illegible due to fading and bleed-through. The text appears to be organized into several paragraphs or sections, with some lines being more prominent than others. The handwriting is cursive and somewhat slanted. There are two large black circular marks on the right side of the page, possibly punch holes or ink marks.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01030						01004					
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New Jersey b. COUNTY					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN ID 17 Days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Morristown 67-3					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Maryland						d. STREET ADDRESS 1 Alpine Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Michael Joseph Quigley, Jr.			First Middle Last			4. DATE OF DEATH January 22 19 66		Month Day Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 4 September 1907		9. AGE (in years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer				10b. KIND OF BUSINESS OR INDUSTRY Law		11. BIRTHPLACE (County & State, or foreign country) New Jersey				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael J. Quigley, Sr.						14. MOTHER'S MAIDEN NAME Crissie Taylor					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 147-05-9661		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Superior Mesenteric Arterial Occlusion 4211 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO C Aortic Stenosis DUE TO B Magovern Valve Aortic replacement										INTERVAL BETWEEN ONSET AND DEATH 10 hours 3 years 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (this hospital) attended the deceased from 5 January 19 66 to 22 January 19 66 that (we) last saw the deceased alive on 22 January 19 66, and that death occurred at 6:05 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Douglas M. Behrendt, MD.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 22 January 1966			
22c. PHYSICIAN'S NAME (Type) Douglas M. Behrendt, MD.						22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				23b. DATE THEREOF 1/24/66		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory				23d. LOCATION (City, town or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR James B. Reed Emily-Whitely Funeral Home						ADDRESS 1500 W. Ballpark Alexandria, Va.		25a. REC'D BY REGISTRAR JAN 26 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
01031			CERTIFICATE OF DEATH				01005		
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>			c. LENGTH OF STAY IN 1b <i>DOA</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brentwood</i> <i>16-2</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>					d. STREET ADDRESS <i>3905 39th ST E</i>				
3. NAME OF DECEASED (Type or print) First <i>Eleanor</i> Middle <i>F.</i> Last <i>Rabbitt</i>					4. DATE OF DEATH Month <i>January</i> Day <i>17</i> Year <i>1966</i>				
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>March 11, 1900</i>		9. AGE (In years last birthday) <i>65</i> yrs. <i>18</i> Months <i>16</i> Days <i>16</i> Hours <i>16</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secretary</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>BROOKINGS FDT.</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Mass</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Joseph H. Furey</i>					14. MOTHER'S MAIDEN NAME <i>Sarah Crowe</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>065-18-4787</i>		17. INFORMANT <i>Brother in law Preston Ted Westbrook Jr.</i> Address <i>4519 Westbrook Ln.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary insufficiency</i> 5271 DUE TO (b) <i>Pulmonary emphysema</i> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <i>54 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arteriosclerotic heart disease</i>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>12-16</i> 19 <i>65</i> , to <i>1-17</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>12-16</i> 19 <i>65</i> , and that death occurred at <i>12:30 PM</i> , from causes and on the date stated above.									
22a. SIGNATURE <i>Harold M. Silver</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <i>1-17-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>HAROLD M. SILVER</i>					22d. ADDRESS <i>1601 18th ST. N.W. WASH DC.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial-transit 1/19/66</i>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <i>St. Joseph's Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Pittsfield, Mass.</i>		
24. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i> <i>Bethesda, Md.</i>					25a. REC'D BY REGISTRAR <i>JAN 20 1966</i>		25b. REGISTRAR'S SIGNATURE <i>John Charles Judge</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01032 CERTIFICATE OF DEATH 01006

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chevy Chase		d. STREET ADDRESS 6131 Nevada Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Julius		First		Middle John		Last Radice		4. DATE OF DEATH Jan		Day 15		Year 1966											
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 22, 1907		9. AGE (In years last birthday) 58 yrs.		IF UNOER 1 YEAR Months Days Hours Min.		IF UNOER 24 HRS.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Orthopedic Surgeon				10b. KIND OF BUSINESS OR INDUSTRY -				11. BIRTHPLACE (County & State, or foreign country) District of Columbia				12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME Peter A. Radice								14. MOTHER'S MAIDEN NAME Adelina Spinelli															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 578-18-6914				17. INFORMANT Milton E. Magruder				Address 4631 Verplanck Place, N.W.											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis (c) Essential Hypertension												INTERVAL BETWEEN ONSET AND DEATH 13 yr 20 yr											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1952, 19 to 7/15, 1966, that (I) (we) last saw the deceased alive on 7/14, 1966, and that death occurred at 7:15 P.M. from the causes and on the date stated above.																							
22a. SIGNATURE E. Herbert Bakersfeld																M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED Jan 15, 1966			
22c. PHYSICIAN'S NAME (Type) E. Herbert Bakersfeld																22d. ADDRESS 1912 R S L NW Wash DC							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 1-19-1966				23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d. LOCATION (City, town or county) (State) Suitland Md											
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash. DC																							
25a. REC'D BY REGISTRAR Jan 19 1966																25b. REGISTRAR'S SIGNATURE J. Charles Judge							

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
01007											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>68 Holy Cross Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>13415 Dauphine St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>Celia</u> First <u>A.</u> Middle <u>Raymond</u> Last			4. DATE OF DEATH <u>JAN.</u> Month <u>2</u> Day <u>1966</u> Year			5. SEX <u>F</u>			6. COLOR OR RACE <u>W</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>1/2/84</u>			9. AGE (In years last birthday) <u>82</u> yrs.			10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H. W.</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>Rumania</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>*****Altman</u>					14. MOTHER'S MAIDEN NAME <u>Jennie</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>M. A. Altschuler</u> Address <u>Sil. Spg., MD</u> <u>13415 Dauphine St.</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>acute myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Impetuous heart failure - pulmonary edema</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 28, 1965</u> , to <u>1-2, 1966</u> that (I) (we) last saw the deceased alive on <u>1-2, 1966</u> , and that death occurred at <u>8 PM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>Jas M. Beiger, M.D.</u>			22b. DATE SIGNED <u>1-3-66</u>			22c. PHYSICIAN'S NAME (Type) <u>Jas M. Beiger, M.D.</u>					
22d. ADDRESS <u>200 Pershing Drive</u> <u>Silver Spring, Md.</u>			23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>								
23b. DATE THEREOF <u>1/5/66</u>			23c. NAME OF CEMETERY OR CREMATORY <u>King David Mem. Garden Falls Church, Virginia</u>			23d. LOCATION (City, town or county) (State)					
24. FUNERAL DIRECTOR <u>B. Danzansky & Sons</u>			25a. REC'D BY REGISTRAR <u>JAN 4 1966</u>			25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>					

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

01034

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01008

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 1½ hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Raymond (nmr) Reid		4. DATE OF DEATH Month January Day 17 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/15/20
9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 17 Months 17 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Printing	
11. BIRTHPLACE (State or foreign country) Scranton, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Reid		14. MOTHER'S MAIDEN NAME Jean Andrew	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W. II		16. SOCIAL SECURITY NO. 169-18-8224	
17. INFORMANT William Reid Address 1612 South Springwood Dr. Wife, Evonence State, Baltimore, D.C., Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial insufficiency with DUE TO thrombosis and coronary artery heart disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 4201 DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		22. DATE SIGNED JAN. 18, 1966.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-20-66	
23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.		25a. REC'D BY REGISTRAR JAN 24 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

20019

State of Ohio - Auditor General
Office of the Auditor General
Columbus, Ohio

Page 1 of 1



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Item 2d Film G373 1/28/66 mm

01035

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01009

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (rural)</u>				c. LENGTH OF STAY IN ID			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>				e. STREET ADDRESS <u>3502 Monroe St. Manor Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>O.</u> Last <u>Reimer</u>				4. DATE OF DEATH <u>January 8 1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 12, 1914</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR <u>10</u> Months <u>26</u> Days		IF UNDER 24 HRS. <u>8</u> Hours <u>15</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dietation</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Govt</u>			
11. BIRTHPLACE (State or foreign country) <u>Kansas</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>George F. Reimer</u>				14. MOTHER'S MAIDEN NAME <u>Agatha Edigeo</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>478-36-1522</u>			
17. INFORMANT <u>N.I.H. Hosp. Records</u>				Address <u>Bethesda, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Trauma-</u> <u>9195</u> DUE TO (b) <u>Gunshot wound of head</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>45 Min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Shot by stray bullet from 8 mm. mouser.</u>			
20c. TIME OF INJURY Month, Day, Year <u>1:15</u> Hour <u>1/8</u> 19 <u>66</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>	
20f. (City or town) <u>Rockville</u> (County) <u>Mont.</u> (State) <u>Md.</u>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u>				22. DATE SIGNED <u>1/8/66</u>			
EXAMINER'S NAME (Type) <u>John G. Ball M. D.</u>				Address (Street, city, town, or county) <u>Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<u>Burial-transit</u>		<u>1-11-66</u>		<u>Buhler Cemetery</u>		<u>Buhler, Kansas.</u>	
24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>	
				DATE <u>JAN 12 1966</u>		25b. REGISTRAR'S SIGNATURE	

0100

0100

U. S. Naval Hospital
Annapolis, Maryland
Distention
George F. Hain
Annapolis, Maryland
Feb. 10, 1914
Annapolis, Maryland
Distention
George F. Hain
Annapolis, Maryland

W-25-1-123
Annapolis, Maryland
Distention
George F. Hain
Annapolis, Maryland
Feb. 10, 1914
Annapolis, Maryland
Distention
George F. Hain
Annapolis, Maryland

John D. Bell, M. D.
Annapolis, Maryland
Distention
George F. Hain
Annapolis, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chevy Chase c. LENGTH OF STAY IN 1b Chevy Chase d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5320 Willard Avenue					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chevy Chase d. STREET ADDRESS 5320 Willard Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) EDWIN C. REYNOLDS			4. DATE OF DEATH Month Jan. Day 9, Year 1966						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 26, 1870		9. AGE (In years last birthday) 95 IF UNDER 1 YEAR: Months 11 Days 13 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Examiner-Patent Off. Gov't-Retired			10b. KIND OF BUSINESS OR INDUSTRY Rhode Island			11. BIRTHPLACE (County & State, or foreign country) U. S.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Edwin Reynolds					14. MOTHER'S MAIDEN NAME Harriett Collins				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Hazel V. Reynolds Address Same as Item 2.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis heart disease 4200 DUE TO (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 12-28-65 , to 1-9-66 , that (I) (we) last saw the deceased alive on 12-28-65 19 66 , and that death occurred at 1:30 M, from the causes and on the date stated above.									
22a. SIGNATURE W. T. JOYCE					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-10-66		
22c. PHYSICIAN'S NAME (Type) W. T. JOYCE					22d. ADDRESS 4977 Battery Lane, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 1-12-66		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City, town or county) (State) Suitland, Maryland			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY ADDRESS Bethesda, Maryland					25a. REC'D BY REGISTRAR 13 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

0310

1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

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1997-1998

22-01-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY PRINCE GEORGE				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING			c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Adelphi 16x.2			d. STREET ADDRESS 1900 Wooded Court	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) FAIRLAND NURSING HOME					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) AIFRED			First S Middle RICH Last		4. DATE OF DEATH 1 - 9 - 1966		Month 1 Day 9 Year 1966		
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-17-1978		9. AGE (In years last birthday) 87 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Architect-U.S. Government				10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (County & State, or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME JAMES P RICH					14. MOTHER'S MAIDEN NAME MARTHA BRADER				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. ---		17. INFORMANT Jean R. Denton Address same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 Arteriosclerotic Vascular Disease DUE TO (b) Senility DUE TO (c) Senility PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Phlebotomy									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Nov 65 to Jan 66 , that (I) (we) last saw the deceased alive on Jan 9 1966 , and that death occurred at 10 PM from the causes and on the date stated above.									
22a. SIGNATURE Bernard A. Fitzgerald M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-9-66		
22c. PHYSICIAN'S NAME (Type) BERNARD A. FITZGERALD					22d. ADDRESS 2714 Univ. Blvd E, AS. Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 1/12/66		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery			23d. LOCATION (City, town or county) (State) Washington, D.C.		
24. FUNERAL DIRECTOR The S.H. Hines Co. Washington, D.C.					25a. REC'D BY REGISTRAR JAN 12 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

MEDICAL CERTIFICATION

01011

01011

[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01038

01012

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Germanstown, Maryland		c. LENGTH OF STAY IN 1b 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Marylander Rest Home		d. STREET ADDRESS 4502 Everett St. Germanstown, Maryland	
3. NAME OF DECEASED (Type or print) Cora Ellen Ricketts		4. DATE OF DEATH January 20 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 3, 1886
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lawrence Lowe		14. MOTHER'S MAIDEN NAME Cora R. Selby	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 215-54-5180	
17. INFORMANT Claudia Papale		Address 5704 Randolph Road Rockville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 13 days 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/32 , 19 64 , to 1/20 , 19 66 , that (I) (we) last saw the deceased alive on 11/17 , 19 66 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE James P. Kerr		22b. DATE SIGNED 1/21/66	
22c. PHYSICIAN'S NAME (Type) James P. Kerr		22d. ADDRESS 26618 Ridge Rd. Damascus, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 24, 1966	
23c. NAME OF CEMETERY OR CREMATORY Darnestown Cemetery		23d. LOCATION (City, town or county) (State) Darnestown, Maryland	
24. FUNERAL DIRECTOR Tyson Wheeler		25a. REC'D BY REGISTRAR DATE 26 1966	
25b. REGISTRAR'S SIGNATURE J. Williams Judge			

01010

01010

1931 Louisville Park
1931 Louisville Park
1931 Louisville Park

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT

Items 18-21 Film G373 2/17/66 T2
 MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakoma Park</u> c. LENGTH OF STAY IN 1b <u>54 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. San. & Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>1130 KALMIA RD, NW</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nelly</u> First <u>IRENE</u> Middle <u>RIGGLES</u> Last 4. DATE OF DEATH <u>JAN. 7 1966</u> Month <u>JAN.</u> Day <u>7</u> Year <u>1966</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>8-19-82</u> 9. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher (Ret.)</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>EDUC.</u> 11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Thomas Riggles</u> 14. MOTHER'S MAIDEN NAME <u>Annie Willow</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Guerry R. Smith</u> Address <u>46612 Dittmar Road N. Arlington, Virginia</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism; myocardial insufficiency;</u> DUE TO (b) <u>Arteriosclerotic heart disease.</u> DUE TO (c) <u>4200</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Deceased fell at home</u>	
20c. TIME OF INJURY Month, Day, Year <u>6:30</u> Hour <u>AM</u> <u>11/14/65</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) <u>Washington</u> (County) <u>D.C.</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> EXAMINER'S NAME (Type) <u>BELDEN R. REAP</u>		22. DATE SIGNED <u>JAN. 8, 1966</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>1-11-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u> 23d. LOCATION (City, town or county) <u>Washington D.C.</u> (State)		24. FUNERAL DIRECTOR <u>Glenn E. Warner</u> ADDRESS <u>18434 Georgia Avenue Silver Spring, Md.</u> 25a. REC'D BY REGISTRAR <u>JAN 13 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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Classified by Dr. Reap

VR A15ME (5)
6M 1/66

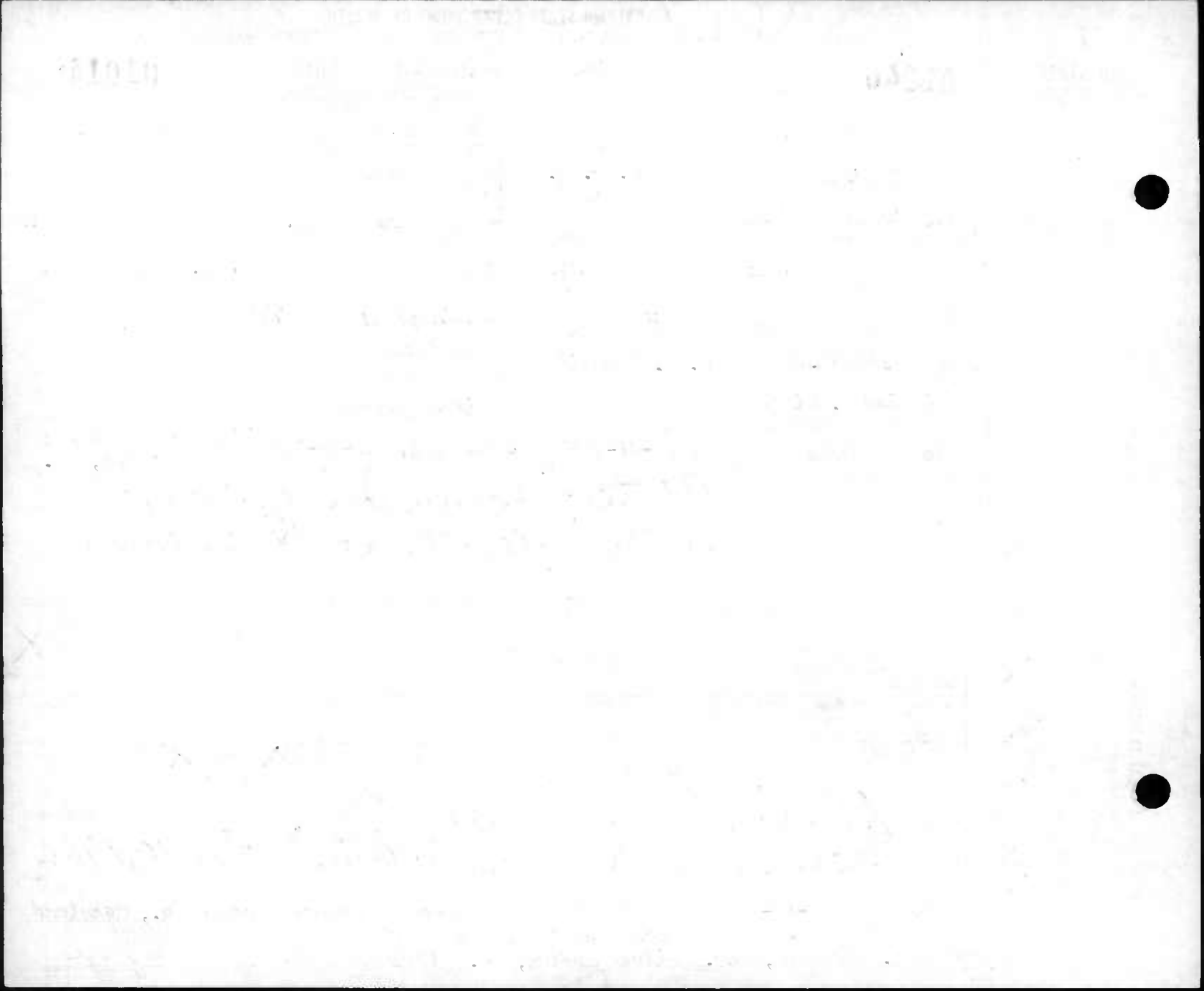
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01040

01014

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 2122 Arcola Ave.	
3. NAME OF DECEASED (Type or print) First John Middle Calvin Last Riggs		4. DATE OF DEATH Month Jan. Day 9 Year 19 66	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/17/1919
9. AGE (In years lost birthday) 74 yrs.		IF UNDER 1 YEAR Months 7 Days 4 Hours 15 Min. 15-1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic Retired		10b. KIND OF BUSINESS OR INDUSTRY D. C. Transit	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? US A	
13. FATHER'S NAME William P. Riggs		14. MOTHER'S MAIDEN NAME Miriam Heacox	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 307-01-6662	
17. INFORMANT John Long, Son-in-law		Address 2122 Arcola Avenue Silver Spring, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO (b) Arteriosclerotic Heart Disease. DUE TO (c) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED JAN. 10, 1966		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-13-66	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Prince Georges Co., Maryland	
24. FUNERAL DIRECTOR Warner C. Pumphrey, Inc.		25a. REC'D BY REGISTRAR 17 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S NAME Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01041

01015

<p>1. PLACE OF DEATH a. COUNTY <u>Montg.</u> <u>MARYLAND</u></p>				<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u></p>			
<p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring,</u></p>				<p>c. LENGTH OF STAY IN 1b <u>? 404RS</u></p>			
<p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u></p>				<p>d. STREET ADDRESS <u>833 Gist Ave.</u></p>			
<p>3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>L ee</u> Last <u>Rinker</u></p>				<p>4. DATE OF DEATH Month <u>January</u> Day <u>28</u> Year <u>1966</u></p>			
<p>5. SEX <u>Female</u></p>		<p>6. COLOR OR RACE <u>White</u></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>10/28/1870</u></p>	
<p>9. AGE (in years last birthday) <u>95 yrs.</u></p>		<p>10. KIND OF BUSINESS OR INDUSTRY <u>At Home</u></p>		<p>11. BIRTHPLACE (County & State, or foreign country) <u>Mt. Jackson, Virginia</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u></p>				<p>11. BIRTHPLACE (County & State, or foreign country) <u>Mt. Jackson, Virginia</u></p>			
<p>13. FATHER'S NAME <u>Lemuel H. Rinker</u></p>				<p>14. MOTHER'S MAIDEN NAME <u>Mary E. Zirkle</u></p>			
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u></p>				<p>16. SOCIAL SECURITY NO. <u>YES-</u></p>		<p>17. INFORMANT <u>Mrs. Walter Brown</u> Address <u>833 Gist Avenue Silver Spring, Md.</u></p>	
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHF</u> (Congestive heart failure) DUE TO (b) <u>ASHD</u> (Arteriosclerotic heart disease) DUE TO (c) <u>20yrs</u></p>						<p>INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u></p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)</p>							
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>			
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u></p>				<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>	
<p>20f. (City or town) (County) (State)</p>				<p>21. I certify that (I) (this hospital) attended the deceased from <u>7-15, 1965</u> to <u>1-28, 1966</u>, that (I) (we) last saw the deceased alive on <u>8-15, 1966</u>, and that death occurred at <u>7:30 AM</u>, from the causes and on the date stated above.</p>			
<p>22a. SIGNATURE <u>George F. Sengstack, M.D.</u></p>				<p>22b. DATE SIGNED <u>1-28-66</u></p>		<p>22c. PHYSICIAN'S NAME (Type) <u>George F. Sengstack, M.D.</u></p>	
<p>22d. ADDRESS <u>9241 Columbia Blvd., Silver Spring, Md.</u></p>				<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>			
<p>23b. DATE THEREOF <u>1-31-66</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u></p>		<p>23d. LOCATION (city, town or county) (State) <u>Washington, D. C.</u></p>		<p>24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u></p>	
<p>25a. REC'D BY REGISTRAR <u>FEB 3 1966</u></p>				<p>25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u></p>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1/28/66 7:45 Body released by Dr. Rinker / Silver Spring

21010

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01042

01016

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>15-1</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Boyd</u> d. STREET ADDRESS <u>Rt #1 Shadel Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Baby Girl A Robertson</u> First Middle Last				4. DATE OF DEATH <u>Jan 26 1966</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 25, 1966</u>	
9. AGE (in years last birthday) <u>14</u> yrs. Months Days		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland, Mont.</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <u>John Robertson</u>			
14. MOTHER'S MAIDEN NAME <u>Nancy Ann Poole</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> 7685 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-25</u> , 19 <u>66</u> , to <u>1-26</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1-26</u> 19 <u>66</u> and that death occurred at <u>8:55</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Michael W. Cuel</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>1/28/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hospital</u>		23d. LOCATION (City, town or county) (State) <u>Bethesda-Montgomery-MD.</u>	
24. FUNERAL DIRECTOR <u>Mrs. Amelia Carter, Administrator</u>				25a. REC'D BY REGISTRAR <u>FEA</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				DATE <u>FEB 1 1966</u>			

6-168509

01010

01010

Handwritten signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
01043						CERTIFICATE OF DEATH						01017	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boyle</u> d. STREET ADDRESS <u>Rt #1 Slidell Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Girl</u> First <u>"B"</u> Middle <u>Robertson</u> Last <u>Robertson</u>						4. DATE OF DEATH <u>Jan 25-</u> Month <u>Jan</u> Day <u>25</u> Year <u>1966</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 25, 1966</u>		9. AGE (In years last birthday) <u>11</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u>		IF UNDER 24 HRS. Hours <u>11</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Bethesda, Mont Co</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John David Robertson</u>						14. MOTHER'S MAIDEN NAME <u>Nancy Ann Poole</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>mother</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary insufficiency</u> <u>7625</u> DUE TO <u>atelectasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Pneumonia</u> (b) <u>Pneumonia</u> (c) <u>Pneumonia</u>												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>1-25</u> , 19 <u>66</u> , to <u>1-26</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1-25</u> , 19 <u>66</u> , and that death occurred at <u>2:00</u> p.m. from the causes and on the date stated above.													
22a. SIGNATURE <u>Medauley Auld</u>						M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>1-26-66</u>	
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS							
23a. BURIAL CREMATION, REMOVAL (Specify)				23b. DATE THEREOF <u>1/28/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hospital</u>				23d. LOCATION (City, town or county) (State) <u>Bethesda-Montgomery MD.</u>			
24. FUNERAL DIRECTOR <u>Mrs. Amelia C Carter Administrator</u>						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
						DATE <u>FEB 1 1966</u>							

6-168482

1010

1010

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01044 CERTIFICATE OF DEATH 01018											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>47-3</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Chey Chase Convalescent and Nursing Center</u>						d. STREET ADDRESS <u>1458 Columbia Road, N.W.</u>					
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>M.</u> Last <u>Rollow</u>						4. DATE OF DEATH Month <u>1</u> Day <u>19</u> Year <u>1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 27, 1877</u>		9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>22</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Government - Printing Office</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Printing Office</u>					
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME <u>Frederick Volk</u>						14. MOTHER'S MAIDEN NAME <u>Margaret Heunch</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>						16. SOCIAL SECURITY NO. <u>no</u>					
17. INFORMANT <u>Robert R. Stone-813 Bright St.</u>						Address <u>Fredericksburg Va.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>complete heart block</u> 6 yrs (c) <u>6 yrs</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>						20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 19, 1966</u> , to <u>Jan 19, 1966</u> , that (I) (we) last saw the deceased alive on <u>Jan 19, 1966</u> , and that death occurred at <u>5 P</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>H F Kreuzburg</u>						22b. DATE SIGNED <u>1/19/66</u>					
22c. PHYSICIAN'S NAME (Type) <u>H F Kreuzburg</u>						22d. ADDRESS <u>7852 16th Ave NW DC</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						23b. DATE THEREOF <u>1/22/66</u>					
23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>						23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>					
24. FUNERAL DIRECTOR <u>The S. H. Hines Co.</u>						25a. REC'D BY REGISTRAR <u>Jan 24 1966</u>					
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											

1915

1915

UNITED STATES OF AMERICA

James H. Smith

James H. Smith

James H. Smith

James H. Smith

Washington, D. C.

Washington, D. C.

Washington, D. C.

Washington, D. C.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01019

01045

FOR STATE HEALTH DEPT.

(M)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital				d. STREET ADDRESS 306 Lanark Way			
3. NAME OF DECEASED (Type or print) First COLEN Middle EUGENE Last ROSS				4. DATE OF DEATH Month January Day 29 Year 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 9/24/1919		9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electronic Engineer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Government		11. BIRTHPLACE (State or foreign country) Seamore, Indiana		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Walter J. Ross				14. MOTHER'S MAIDEN NAME Bertha			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-44-2780		17. INFORMANT Mrs. Eva B. Ross - 306 Lanark Way			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO Coronary Artery Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4201 (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) BELDEN R. REAP		M.D. BELDEN R. REAP		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED JAN. 31, 1966	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-2-66		23c. NAME OF CEMETERY OR CREMATORY Washington National Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.				25a. REC'D BY REGISTRAR Feb 4 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

01010

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01046

01020

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN lb <u>4 Months 1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>FAIRBOND NURSING HOME</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Pr. Ges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u> d. STREET ADDRESS <u>504 FAIRLAWN AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>IRENE ELIZABETH ROWE</u> First Middle Last 4. DATE OF DEATH <u>1 16 1966</u> Month Day Year		5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>3/31/92</u> 9. AGE (in years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>House</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>MILLARD SCHOOLEY</u> 14. MOTHER'S MAIDEN NAME <u>LOUISE JOHNSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>504 Fairlawn Ave</u> 17. INFORMANT <u>E. J. Rowe, Laurel, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4500 Cordiac failure</u> DUE TO (b) <u>same</u> DUE TO (c) <u>same</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> to <u>1965</u> , that (I) (we) last saw the deceased alive on <u>1965</u> , and that death occurred at <u>9:15 P.M.</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Odolando Pierandrea</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>Odolando Pierandrea</u> 22d. ADDRESS <u>Laurel, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>1-19-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>St Mary Cem</u> 23d. LOCATION (City, town, or county) (State) <u>Laurel Md</u>		24. FUNERAL DIRECTOR <u>Robert J. Donaldson</u> ADDRESS <u>Laurel Md</u> 25a. REC'D BY REGISTRAR <u>Jan 25 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01050

01050

01050

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01021

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Resmore Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria d. STREET ADDRESS 624 S. Lee Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FRANCES WHITE ROWNTREE		4. DATE OF DEATH Month January Day 4 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 23, 1874
9. AGE (in years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) Kansas
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Fredric White	
14. MOTHER'S MAIDEN NAME Mary Leslie		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None	
16. SOCIAL SECURITY NO. None		17. INFORMANT Richardson H. Rowntree Address 624 S. Lee Street Alexandria, Virginia	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Mar. 21, 1957 to Jan. 4, 1966 , that (I) (we) saw the deceased alive on Jan. 4, 1966 , and that death occurred at 120 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Thomas L. Hartman		22b. DATE SIGNED 1/4/66	22c. PHYSICIAN'S NAME (Type) THOMAS L. HARTMAN
22d. ADDRESS 2001 Eye St. N.W.		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF Jan. 4, 1966	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	23d. LOCATION (City, town or county) (State) Suitland Maryland
24 FUNERAL DIRECTOR'S SIGNATURE G.E. Sutphin ADDRESS 2847 Wilson Boulevard Arlington, Virginia		25a. REC'D BY REGISTRAR JAN 6 1966	25b. REGISTRAR'S SIGNATURE John Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1901-10

RECORDS OF DEATH

1901-10

ROTHMAN

WHITE

FR W 2

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

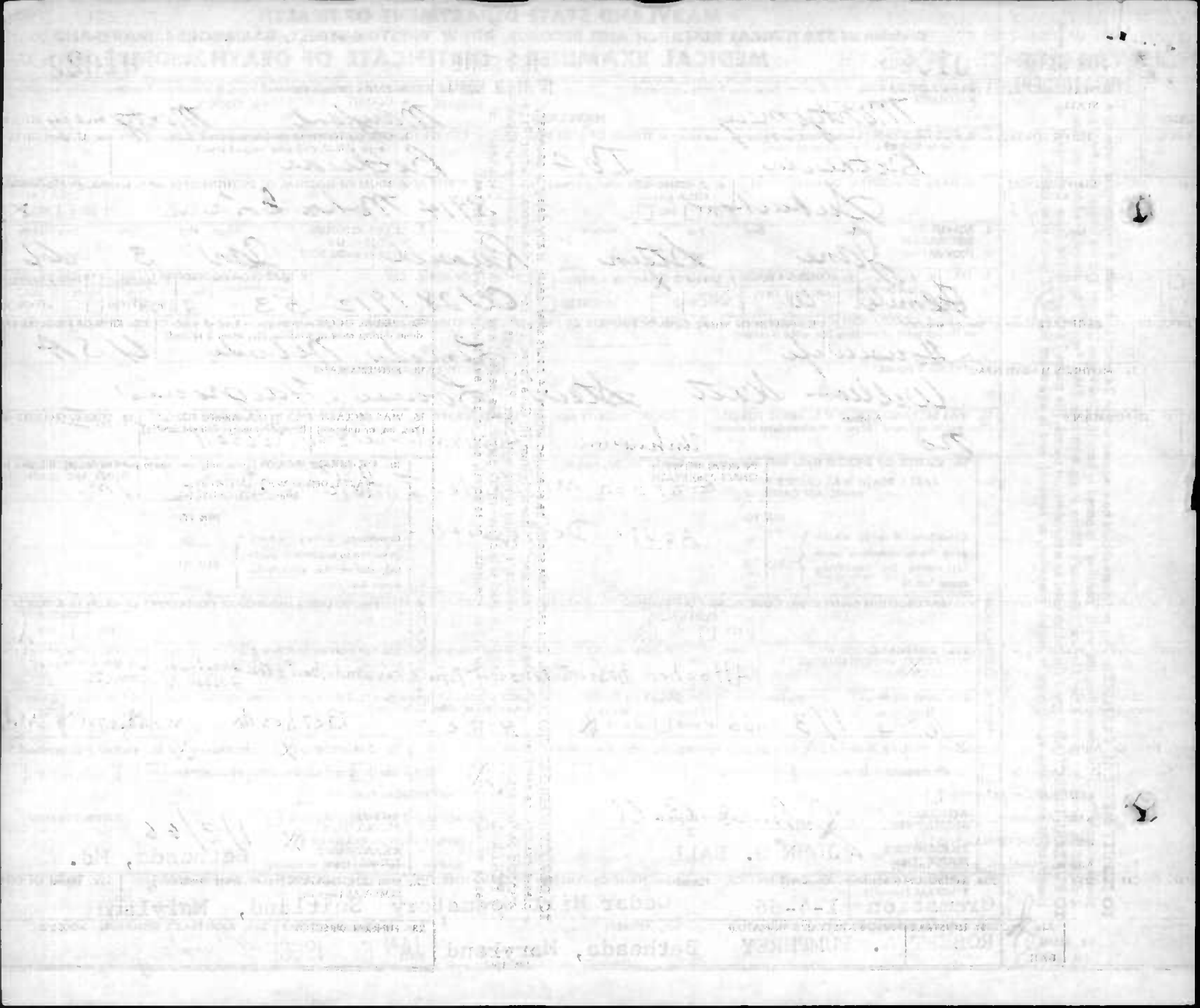
1
FOR STATE
HEALTH DEPT.

01048

01022

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>DoA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>8914 McLaw Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jane Stein Russell</u>				4. DATE OF DEATH Month Day Year <u>Jan 3 1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 28, 1912</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months Days <u>2 5</u>		IF UNDER 24 HRS. Hours Min. <u>5 3</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Lincoln, Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William Kate Stein</u>				14. MOTHER'S MAIDEN NAME <u>Louise Hargroves</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Husband - Gerald Russell same as II.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon Monoxide Inhalation.</u> <u>9731</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Acute Depression -</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Attached hose to exhaust pipe of car and put other end in car window & started motor.</u>					
20c. TIME OF INJURY Month, Day, Year <u>10 a.m. 1/3 1966</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Bethesda - Montgomery Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John S. Ball</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>1-4-66</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>JAN 6 1966</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



7 1 X
FOR STATE HEALTH DEPT
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

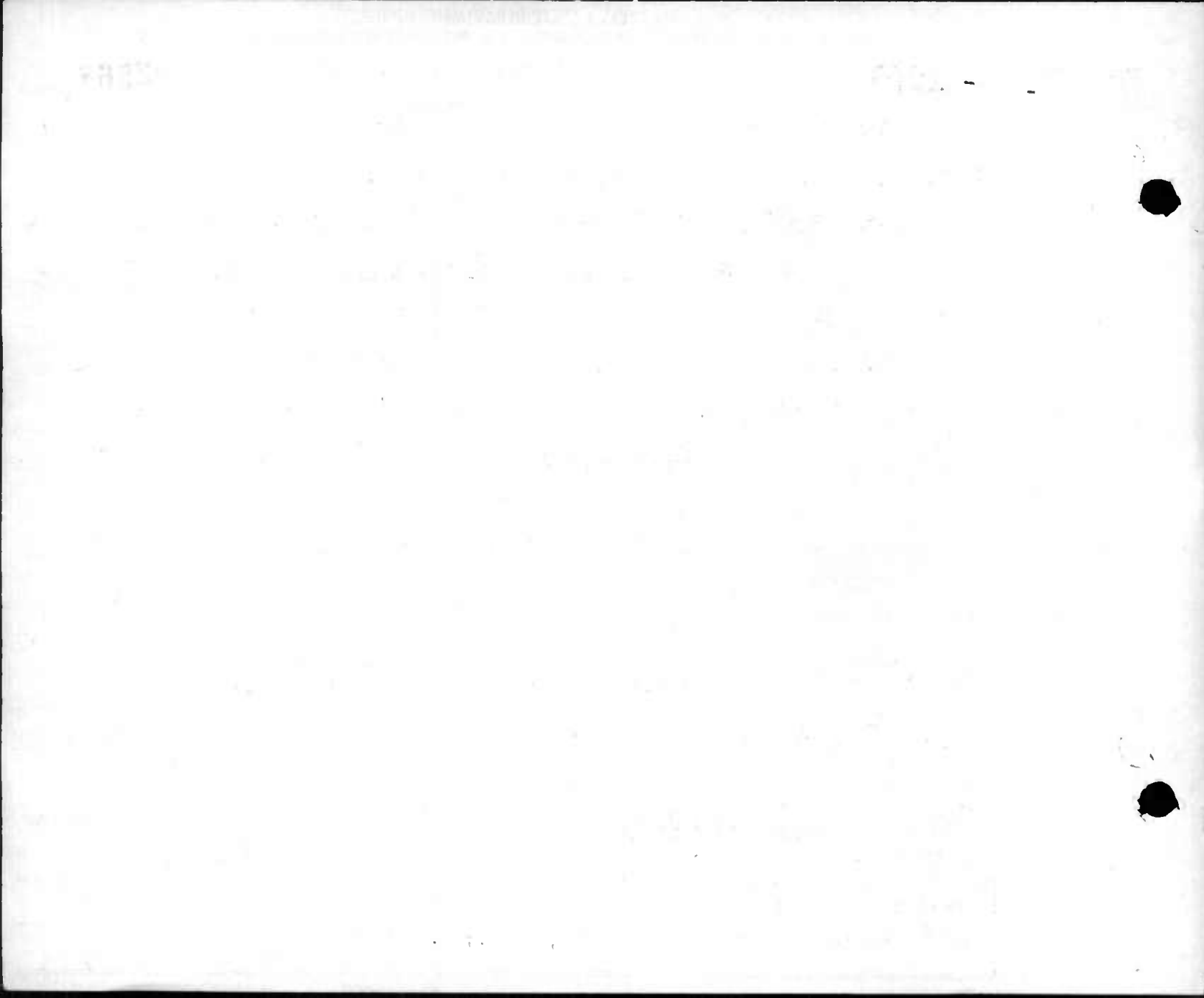
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

-01049

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02568

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route. 355: outside of Rockville</u>		d. STREET ADDRESS <u>15912 Frederick Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Andrew Clifford Rutherford</u>		4. DATE OF DEATH Month Day Year <u>Jan 30 1966</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/13/20</u>
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>45</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jeff Rutherford</u>		14. MOTHER'S MAIDEN NAME <u>Frankie Birch Field</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war, or dates of service) <u>Yes - W.N. #1</u>		16. SOCIAL SECURITY NO. <u>242-22-9519</u>	
17. INFORMANT <u>Robert Sam. Rutherford</u>		Address <u>4118 Docton Rd. Kensington Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypothermia</u> DUE TO <u>9328</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Exposure to extreme cold weather</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>walked in snow blizzard and froze</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>10</u> p.m. <u>1/30</u> 19 <u>66</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Field</u>		20f. (City or town) (County) (State) <u>Rockville Montgomery Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <u>2/6/66</u>	
ACTUAL SIGNATURE <u>John S. Ball</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>2/11/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington Virginia</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u>		1331 Rockville Pike, Rock., Md.	
25a. REC'D BY REGISTRAR <u>FEB 10 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> c. LENGTH OF STAY IN b <i>2 yrs.</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>90 Aether Woodland Nursing Home 1000 Doleview Rd 1707 Columbia Rd D.C.</i>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <i>DC</i> b. COUNTY <i>Washington D.C. 42-3</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington D.C. 42-3</i> d. STREET ADDRESS <i>1707 Columbia Rd D.C.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Margaret A Ryan</i>		4. DATE OF DEATH Month <i>Jan</i> Day <i>1</i> Year <i>1966</i>					
5. SEX <i>Fe</i>	6. COLOR OR RACE <i>Cauc.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 28 1887</i>	9. AGE (In years last birthday) <i>88</i> yrs.	IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.	IF UNDER 24 HRS. Hours <i>0</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NURSE Clerk U.S. Government</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Government</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Norwich New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William Francis Ryan</i>		14. MOTHER'S MAIDEN NAME <i>MARY Ann Hugh</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> (If yes give war or dates of service) <i>Spanish American</i>			16. SOCIAL SECURITY NO. <i>None</i>
17. INFORMANT <i>Mrs. Ruth L. Morgan</i>		Address <i>4000 Cathedral Ave., N.W. Washington, D.C.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Terminal bronchopneumonia</i> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <i>Cardio vascular disease</i> DUE TO (c) <i>6 yrs.</i>			INTERVAL BETWEEN ONSET AND DEATH <i>4 da</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (the hospital) attended the deceased from <i>May</i> , 19 <i>48</i> to <i>Jan</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Jan 1</i> 19 <i>66</i> , and that death occurred at <i>12 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>H.B. Quayle</i>		22b. DATE SIGNED <i>1-1-66</i>		22c. PHYSICIAN'S NAME (Type) <i>H.B. Quayle</i>			22d. ADDRESS <i>1722 Biltmore St N.W. Washington D.C.</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1-4-66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Washington, D.C.</i>	
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>		Address <i>2430 Georgia Avenue Silver Spring, Maryland</i>		25a. REC'D BY REGISTRAR <i>JAN 6 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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Montgomery

21-1-1910

Highland Park, N.Y. (Columbia)

1910

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
01051		01024	
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Arkansas b. COUNTY ✓	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Walnut Ridge	
c. LENGTH OF STAY IN 1b 32 days		d. STREET ADDRESS 411 E. Georgia	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry Middle "D" Last Ryburn		4. DATE OF DEATH Month January Day 30 Year 19 66	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 21, 1907
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months 6 Days 9	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Military		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (County & State, or foreign country) Randolph Co., Arkansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Washington Ryburn		14. MOTHER'S MAIDEN NAME Mary Elizabeth Swinney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. 141 14 2831	
17. INFORMANT Mrs. Myrle Callahan		Address 411 Box 256 Black Rock, Ark.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Widespread metastatic carcinoma floor of mouth 143X IMMEDIATE with peri-bronchial metastases and Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) respiratory insufficiency. DUE TO (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from Dec. 29 , 19 65 to Jan. 30 19 66 , that he (we) last saw the deceased alive on Jan. 30 19 66 , and that death occurred at 1:25 P.M. from the causes and on the date stated above.			
22a. SIGNATURE John A. Ramlo		22b. DATE SIGNED Jan. 31, 1966	
22c. PHYSICIAN'S NAME (Type) John A. Ramlo		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 2-2-66		23b. DATE THEREOF 2-2-66	
23c. NAME OF CEMETERY OR CREMATORY Masonic Cemetery		23d. LOCATION (City, town or county) (State) Pocahontas, Arkansas	
24. FUNERAL DIRECTOR 7557 Wisconsin Avenue, R.A. Pumphrey, Bethesda, Md.		25a. REC'D BY REGISTRAR FEB 4 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

01021

01021

Antennae

Antennae

Antennae (ventral)

U. S. Navy Hospital

U. S. Navy Hospital

Antennae

Antennae

Antennae (ventral)

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TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
01052					01025									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)									
a. COUNTY Montgomery					a. STATE Maryland									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg					b. COUNTY Baltimore									
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Asbury Methodist Home					d. STREET ADDRESS 8001 Temple Road									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>														
3. NAME OF DECEASED (Type or print)			First			Middle			Last					
			Harriet			Zelma			Ryder					
4. DATE OF DEATH			Month			Day			Year					
			January			28			19 66					
5. SEX			6. COLOR OR RACE			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH					
F			W			WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			June 14, 1879					
9. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.								
86 yrs.			Months			Days			Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country)				
Housewife										Smyrna, Delaware				
12. CITIZEN OF WHAT COUNTRY?					13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
U.S.A.					Isaac A. Biddle					Martha J. Jones				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT				
no					none					Asbury Methodist Home, Gaithersburg, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										1 wk.				
491X DUE TO														
Conditions, if any, which gave rise to immediate cause (b)														
(a), stating the underlying cause last. DUE TO														
(c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														
Cerebral Arteriosclerosis														
19. WAS AUTOPSY PERFORMED?														
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)														
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year														
Hour a.m. 19														
20d. INJURY OCCURRED														
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>														
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)														
20f. (City or town) (County) (State)														
21. I certify that (I) (this hospital) attended the deceased from 4/1/63, 19 to 1/28/66, 19, that (I) (we) last saw the deceased alive on 1/25/66, 19, and that death occurred at 4:54 AM, from the causes and on the date stated above.														
22a. SIGNATURE														
x Eury C. Braggins M.D.														
22b. DATE SIGNED														
1/28/66														
22c. PHYSICIAN'S NAME (Type)														
22d. ADDRESS														
23a. BURIAL, CREMATION, REMOVAL (Specify)														
Burial														
23b. DATE THEREOF														
1/31/66														
23c. NAME OF CEMETERY OR CREMATORY														
Oaklayn Cemetery, Baltimore County, Md.														
23d. LOCATION (City, town or county) (State)														
Baltimore, Md.														
24. FUNERAL DIRECTOR'S SIGNATURE														
Wm. J. Tickner & Sons North Baltimore														
25a. REC'D BY REGISTRAR														
FEB 1 1966														
25b. REGISTRAR'S SIGNATURE														
Charles Judge														

WLO

01052

01052

